Rocky Mountain Medical Journal

Red Cross Month

March 1954

Vol. 51—No. 3
35c Per Copy
$3.50 Per Year

BICIPITAL TENOSYNOVITIS—UTAH TUMOR REGISTRY
RETROPERITONEAL RADIOGRAPHY WITH OXYGEN INFECTION—VOLVULUS OF SIGMOID COLON
TREATMENT OF TRACHOMA—SUCCESSFUL RESECTION OF HEPATOMA

For Table of Contents, Turn the First Page

Chloromycetin®

(Chloramphenicol, Parke-Davis)

truly one of thos

PARKE, DAVIS

Since its introduction over four years ago, Chloromycetin has been used by physicians in practically every country of the world. More than 11,000,000 patients have been treated with this important antibiotic—

the world's outstanding therapeutic agents.

IS OMPANY MEDICAMENTA VERA P CO. DETROIT 32, MICHIGAN

Table of Contents

VOLUME 51 NUMBER 3
MARCH, 1954

ROCKY MOUNTAIN MEDICAL JOURNAL

Title Registered, U. S. Patent Office

Publication Office:
835 Republic Building (1612 Tremont Place), Denver 2, Colorado
Telephone AComa 0547

Ownership and Sponsorship: The Rocky Mountain Medical Journal is owned by the Colorado State Medical Society and is published monthly as a non-profit enterprise for the mutual benefit of the organizations which jointly sponsor it. It is published under the direction of the Board of Trustees of the Colorado State Medical Society, assisted by an Editorial Board representing the sponsoring organizations. It is the Official Journal of the Colorado State Medical Society, the Montana Medical Association, the New Mexico Medical Society, the Utah State Medical Association, the Wyoming State Medical Society, the Rocky Mountain Medical Conference, and the Colorado Hospital Association.

Manuscripts: Scientific Articles, Case Reports, etc., from any state for which this is the Official Journal should be submitted to the Scientific Editor for that state as named in the Editorial Board, above. Other material from any participating state should be submitted to the Associate Editor for that state as named above. Manuscripts from outside the Rocky Mountain area should be sent direct to the Journal office. Manuscripts must be typewritten, double or triple spaced, using only one side of each sheet. It is the policy of this Journal to omit bibliographies.

Advertising: National representatives: The State Journal Advertising Bureau, 535 North Dearborn Street, Chicago 10, Ill. Local advertising from firms in the Rocky Mountain area should be submitted to the Associate Editor of the appropriate state or to the Journal office. Advertising forms close on the 15th of the month preceding publication; allow ten days additional to insure submitting proofs for approval.

Subscription: $3.50 per year in advance, postpaid in the United States and its possessions; single copy 35c plus postage. Subscription is included in medical society dues of sponsoring state medical organizations.

Second Class Matter: Entered as second class matter Jan. 22, 1906, at the Post Office at Denver, Colo., under the Act of Congress of March 3, 1879. Accepted for mailing at special rates of postage provided for in Section 1103, Act of Oct. 3, 1917; authorized July 17, 1918.

THE COLORADO STATE MEDICAL SOCIETY

NEXT ANNUAL SESSION: BROADMOOR HOTEL, COLORADO SPRINGS, SEPT. 21-25, 1954

OFFICERS

Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated, the term is for one year only and expires at the 1954 Annual Session.

President: Claude D. Bonham, Boulder.

President-Elect: Samuel P. Newman, Denver.

Vice President: Lawrence D. Buchanan, Wray.

Constitutional Secretary (three years): Irvin E. Hendryson, Denver, 1954.

Treasurer (three years): Frank I. Nicks, Colorado Springs, 1956.

Additional Trustees (three years): Robert T. Porter, Greeley, Vice Chairman, 1954; William R. Lipscomb, Denver, 1955; Thomas K. Mahan, Grand Junction, 1955; C. Walter Metz, Denver, 1956.

(The above nine officers compose the voting membership of the Board of Trustees. William A. Liggett, Denver, and Harry C. Bryan, Colorado Springs, immediate Past-Presidents, are ex-officio non-voting Trustees. Dr. Hendryson is Chairman of the Board and Dr. Porter is Vice Chairman for the 1953-54 year.)

Board of Councilors (three years): District No. 1: Paul R. Hildebrand, Brush, 1954; No. 2: Ella A. Mead, Greeley, 1954; No. 3: Osgoode S. Philpott, Denver, 1954; No. 4: Ward C. Fenton, Rocky Ford, 1956; No. 5: Scott A. Gale, Pueblo, 1956; No. 6: Herman W. Roth, Vice Chairman, Monte Vista, 1956; No. 7: Leo W. Lloyd, Chairman, Durango, 1955; No. 8: Harvey M. Tupper, Grand Junction, 1955; No. 9: Ray G. Witham, Craig, 1955.

Board of Supervisors (two years): J. Lawrence Campbell, Denver, 1954; W. S. Cleland, Delta, 1954; Harold E. Haymond, Greeley, 1954; Robert A. Hoover, Salida, 1954; William C. Service, Colorado Springs, 1954; J. Alan Shand, La Junta, 1954; David W. McCarty, Longmont, 1955; Duane F. Hartshorn, Fort Collins, 1955; Geno Saccomanno, Grand Junction, 1955; Kenneth H. Beebe, Sterling, 1955; Albert P. Ley, Monte Vista, 1955; William N. Baker, Pueblo, 1955.

Delegates to American Medical Association (two years): William B. Halley, Denver, 1954; (Alternate: Kenneth C. Sawyer, Denver, 1954); George A. Unfug, Pueblo, 1955; (Alternate: E. H. Munro, Grand Junction, 1955).

Foundation Advocate: Walter W. King, Denver.

House of Delegates: Speaker, Eugene B. Ley, Pueblo; Vice Speaker, John A. Weaver, Jr., Greeley.

Executive Office Staff: Mr. Harvey T. Sethman, Executive Secretary; Mr. Evan A. Edwards, Assistant Executive Secretary; Mrs. Geraldine A. Blackburn, Administrative Assistant; 835 Republic Building, Denver 2, Colo.; Telephone: AComa 0547.

General Counsel: Mr. J. Peter Nordlund, Attorney-at-Law, Denver.

STANDING COMMITTEES

Committee on Constitution, By-Laws and Credentials: James M. Perkins, Chairman, Denver; George Balderston, Montrose; Lawrence L. Hick, Delta; Frank H. Zimmerman, Pueblo; John L. McDonald, Colorado Springs; Eugene Wiege, Greeley; Roger G. Howlett, Golden.

Health Education (two years): Lewis Barbato, Denver, Chairman, 1955; Doris Bencs, Haxtun, 1954; Archer C. Sudan, Grand Junction, 1954; Miss Norma Johannis, Denver, 1954; Donn J. Barber, Greeley, 1954; Richard W. Whitehead, Denver, 1955; William C. Beaver, Grand Junction, 1955; H. Sherwin Johnston, Jr., La Junta, 1955, and Dwight C. Dawson, Canon City, 1955.

Sub-Committee on School Health: Lewis Barbato, Denver, Chairman; Mary L. Moore, Grand Junction; William C. Service, Colorado Springs; W. Lloyd Wright, Golden; Victor E. Cram, Fort Collins; Mariana Gardner, John A. Lichty and Leland M. Corliss, all of Denver.

Library and Medical Literature: Lorenz W. Frank, Chairman, Denver; T. M. Rogers, Sterling; A. J. Helm, Greeley; Nolle Mumey, W. G. Davis, William B. Condon, Glenn T. Foust, Jr., and George D. Wilcox, all of Denver.

Medical Education and Hospitals: William C. Black, Chairman, Denver; Harry H. Lamberson, Colorado Springs; N. L. Beebe, Fort Collins; Kenneth E. Prescott, Grand Junction; Archibald R. Buchanan, Robert S. Liggett, Frank B. McGlone, and Charley J. Smyth, all of Denver.

Medical Service: Fredrick H. Good, Chairman, Denver, 1954; Eugene B. Ley, Pueblo, 1954; Geno Saccomanno, Grand Junction, 1955; Robert K. Brown, 1955, Roy L. Cleere, 1955, Harry C. Hughes, 1954, McKinnie L. Phelps, 1954, and Kenneth C. Sawyer, 1955, all of Denver.

Medical Service Subcommittees:

Distribution of Physicians: Eugene B. Ley, Pueblo, Chairman; Autrey Croke, Colorado Springs; Warren Gillette, Boulder; L. S. Sampson, Las Animas; William T. Boehm, Henry A. Buchtel and John M. Nelson, all of Denver.

Prepayment Services: Harry C. Hughes, Denver, Chairman; J. W. McMullen, Colorado Springs; George E. Garrison, Fort Collins; Robert S. Henderson, Longmont; Raymond A. Nethery, Pueblo; James R. Blair, Jr., Charles G. Freed, Terry J. Gromer, Gilbert R. Hall and Whitney C. Porter, all of Denver.

Indigent Medical Services: McKinnie L. Phelps, Denver, Chairman; Paul A. Draper, Colorado Springs; Everett H. Munro, Grand Junction; George R. Buck and William A. Liggett, Denver.

Medical Care of Veterans: Executive Committee: Robert K. Brown, Denver, Chairman; Frank B. McGlone, Denver, and William B. Condon, Denver. **Additional Members:** Jackson L. Sadler, Fort Collins; William N. Baker, Pueblo; Harvey M. Tupper, Grand Junction; William A. Campbell, Colorado Springs.

Blood Banks: Geno Saccomanno, Grand Junction, Chairman; William A. Rettberg, Vice Chairman, Denver; David R. Akers, Denver; Winthrop B. Crouch, Colorado Springs; and A. J. Miller, Pueblo.

Hospital-Professional Relations: Kenneth C. Sawyer, Denver, Chairman; Adalbert Miskowiec, Center; Everett H. Munro, Grand Junction; Joseph A. Leonard, Lakewood; John A. Weaver, Greeley; George R. Wright, Longmont; Douglas R. Collier, Wheatridge; William M. Ivers, John T. Jacobs, Thomas J. Kennedy, Roderick J. McDonald, Louis A. Pollock, Wendell P. Stampfli, George Wollgast, all of Denver.

Emergency Medical Service: Roy L. Cleere, Denver, Chairman; F. H. Longwell, Denver, Vice Chairman; Kenneth E. Gloss, Colorado Springs; William H. Jackson, Fort Morgan; John W. McDonald, Sterling; L. W. Holden, Boulder; Rudolph E. Giehm, Harry C. Hughes, K. A. Jankovsky, Roderick J. McDonald, Foster Matchett, Marshall G. Nims, Mordant E. Peck, Myron B. Pedigo, Thad P. Sears, Karl F. Sunderland, David L. Wahl, and Arthur R. Woodburne, all of Denver.

Intra-professional Insurance Problems: Ervin A. Hinds, Denver, Chairman; Robert T. Porter, Greeley; George L. Pattee, Marvin E. Johnson, Kester V. Maul, Willis L. Bennett, Bennett W. Muir, E. Stewart Taylor, Mr. J. P. Nordlund, all of Denver.

Liaison Committee With Nurses Organizations: Harold D. Palmer, Chairman; Walter E. Vest, Francis Manlove, Mr. DeMoss Taliaferro, Mr. John E. Lawson, all of Denver.

Medicolegal: (two years): William W. Haggart, Denver, Chairman, 1954; Rudolph W. Arndt, 1954; Hamilton I. Barnard, 1955; Charles S. Bluemel, 1955; Edward J. Meister, 1954; Ralph H. Verploeg, 1955, all of Denver.

Necrology: Frances McConnell-Mills, Denver, Chairman; Roger S. Whitney, Colorado Springs.

Public Health Subcommittees:

Public Health: John I. Zarit, Denver, 1954, Chairman; George A. Unfug, Pueblo, 1954; James S. Cullyford, 1954, William A. Dorsey, 1954, Monroe R. Tyler, 1954, Vernon K. Anderi, 1955, E. L. Binkley, Jr., 1955, Frank C. Campbell, 1955, Edward S. Miller, 1955, Clyde E. Stanfield, 1955, all of Denver.

Cancer Control: Frank C. Campbell, Denver, Chairman; Walter M. Boyd, Greeley; Walter C. Herold, Colorado Springs; Sion W. Holley, Loveland; Stephen B. Phillips, Salida; C. L. Davis (D.V.M.), John B. Grow, N. Paul Isbell, Alexis E. Lubchenco, Harold D. Palmer and Mr. Hugh Terry, all of Denver. **Subcommittee on Cancer Conference:** Frederick H. Brandenburg, Denver, Chairman; Vernon K. Anderl, Frank C. Campbell, W. W. Haggart, Stanley K. Kurland, J. Leonard Swigert, and A. R. Woodburne, all of Denver.

Chronic Diseases: George A. Unfug, Pueblo, Chairman; Lloyd W. Anderson, Sterling; Roland A. Bano, Grand Junction; Nicholas S. Saliba, Walsenburg; David R. Bargiow, Trinidad; Robert H. Smith, Colorado Springs; Miriam C. Benner, Richard C. Cullen and Edward J. Delehanty, all of Denver.

Crippled Children: E. L. Binkley, Jr., Denver, Chairman; Henry N. Russell, Jr., Greeley; Mary L. Moore, Grand Junction; R. H. Mellen, Colorado Springs; Sidney E. Blandford, H. Alexander Bradford and Fred H. Hartshorn, all of Denver.

Industrial Health: James S. Cullyford, Denver, Chairman; Joseph J. Parker, Grand Junction; Arthur W. Evans, Pueblo; Robert F. Bell, Lewis C. Benesh, Maurice D. Gaon, Joseph L. Glaser, George P. Lingenfelter, W. J. Longeway, Sherman S. Pinto, Donald G. Roberts, all of Denver.

Maternal and Child Health: Vernon K. Anderl, Denver, Chairman; W. R. Jacobson, Grand Junction; Mary H. Frantz, Montrose; Maurice E. Snyder, Colorado Springs; Donn J. Barber, Greeley; Garfield F. Hawlick, Pueblo; John H. Amesse, Paul D. Bruns, Lewis R. Day, Ruth B. Howard, Leo J. Flax B. L. Isberg and John D. Whitmore, all of Denver.

Mental Health: Clyde E. Stanfield, Denver, Chairman; F. H. Zimmerman, Pueblo; W. Y. Takahashi, Boulder; Paul A. Draper, Colorado Springs; Karl J. Waggener, Pueblo; William R. Conte, Greeley; Lewis Barbato, R. Robert Cohen, F. G. Ebaugh, John M. Lyon, Norbert L. Shere and Charles A. Rymer, all of Denver.

Rehabilitation: William A. Dorsey, Denver, Chairman; Max M. Leder, Spivak; Kenneth W. Olshausen, Boulder; David Boyer, Pueblo; Martin E. Anderson, Jr., Hamilton I. Barnard, Robert F. Berris, Harold Dinken, Sidney H. Dressler, Bradford Murphey and Mr. Dorsey Richardson, all of Denver.

Rural Health: Monroe R. Tyler, Denver, Chairman; James H. White, Greeley; Mason M. Light, Gunnison; Ernest G. Ceriani, Kremmling; John G. Hedrick, Wray; F. A. Humphrey, Fort Collins; Charles A. Cassidy, Monte Vista; Portia Lubchenco, Sterling; Hugh F. Williamson, Paonia; Albert T. Waski, Akron; V. E. Wohlauer, Brush; James M. Fraser, Grand Lake; Raymond T. Shima, Rocky Ford; Paul E. Tramp, Loveland; Norman A. Brethouwer, Montrose; Mr. Marvin Russell, Denver; Mrs. Tee Sims, Denver.

Sanitation: Edward S. Miller, Denver, Chairman; Harold Grabow, Canon City; Richard L. Davis, La Junta; Fritz Rosenberg, San Luis; C. Oliver Roberts, Boulder; Mr. Jean Breitenstein, E. N. Chapman, Bernard T. Daniels, Lloyd Florio, Mr. William Gahr, J. Burris Perrin, all of Denver.

Tuberculosis Control: John I. Zarit, Denver, Chairman; L. W. Holden, Boulder; Robert J. Groom, Grand Junction; A. M. Mullett, Colorado Springs; William F. Stone, Colorado Springs; H. M. Van Der Schouw, Wheatridge; W. Kemp Absher, Pueblo; H. H. Kerr, Pueblo; John A. Frantz, Montrose; W. J. Hinzelman, Greeley; T. K. Gleichman, Robert S. Liggett, W. S. Prenziau, Arthur Robinson, Louis Rotenberg, all of Denver.

THE COLORADO STATE MEDICAL SOCIETY

Public Policy: G. C. Milligan, Englewood, Chairman; Karl F. Arndt, Denver, Vice Chairman; Paul A. Draper, Colorado Springs; Morgan A. Durham, Idaho Springs; Jackson L. Sadler, Fort Collins; Richard F. LaForce, Sterling; B. T. Daniels, Frank B. McGlone and J. Robert Spencer, all of Denver; Heman R. Bull, Grand Junction; Ward C. Fenton, Rocky Ford; William N. Baker, Pueblo; Ex-officio: Claude D. Bonham, Boulder, President; Samuel P. Newman, Denver, President-Elect; Irvin E. Hendryson, Denver, Constitutional Secretary.

Public Policy Subcommittees:

Legislation: Cyrus W. Anderson, Denver, Chairman; John C. Lundgren, Julesburg; Harry C. Bryan, Colorado Springs; John B. Farley, Pueblo; George A. Unfug, Pueblo; James P. Rigg, Grand Junction; Hamilton I. Barnard, William A. Hines, Roderick J. McDonald, Bradford Murphey, Samuel P. Newman, McKinnie L. Phelps, and Kenneth Sawyer, all of Denver.

Publicity: William B. Condon, Denver, Chairman; John S. Bouslog, Denver, Vice Chairman; Karl F. Arndt, George H. Curfman, Jr., Ira Dixson, Irvin E. Hendryson, Bradford Murphey, Raymond C. Scannell and Clyde E. Stanfield, all of Denver.

Weekly Health Column and Health Articles: Robert P. Harvey, Denver, Chairman; George H. Curfman, Jr., Frank C. Campbell, Charles R. Freed, Charles G. Gabelman, John G. Hemming, Jr., Joseph B. McCloskey, William A. Mayer, Jr., Aaron Paley, Donald K. Perkin, Seymour E. Wheelock, all of Denver.

Rocky Mountain Medical Conference: George P. Lingenfelter, Denver, 1957, Chairman; D. W. Macomber, 1954; Terry J. Gromer, 1955; William Covode, 1956; and L. Clark Hepp, 1958, all of Denver.

Scientific Program: William R. Coppinger, Denver, Chairman; Frederick H. Brandenburg, Denver, Vice Chairman; John W. Bradley, Colorado Springs; Kenneth W. Dumars, Jr., Colorado Springs; Edgar A. Eliff, Sterling; Vernell W. Curry, Pueblo; Willis L. Bennett, Samuel B. Childs, Felice A. Garcia, Chauncey A. Hager, Gordon Meiklejohn, E. Paul Sheridan and E. Stewart Taylor, all of Denver.

SPECIAL COMMITTEES

Advisory to Auxiliary: Bernard T. Daniels, Denver, Chairman; William R. Lipscomb, Denver; Harry C. Bryan, Colorado Springs.

Advisory to U.M.W. Welfare Fund (three years): John S. Bouslog, Denver, 1954, Chairman; E. B. Ley, Pueblo, 1954; Mason M. Light, Gunnison, 1954; James M. Lamme, Sr., Walsenburg, 1955; Ligon Price, Mt. Harris, 1955; R. J. Ralston, Holyoke, 1955; Gilbert Balkin, Denver, 1956; Royal H. Finney, Pueblo, 1956; W. W. Haggart, Denver, 1956.

American Medical Education Foundation: James P. Rigg, Grand Junction, Chairman; James R. Kennedy, Colorado Springs; Robert T. Porter, Greeley; Lester L. Ward, Pueblo; J. Lawrence Campbell, Atha Thomas, Ervin A. Hinds and William A. Liggett, all of Denver.

Automotive Safety: Horace E. Campbell, Denver, Chairman; Freeman D. Fowler, Idaho Springs; Edward H. Vincent, Colorado Springs; William C. Beaver, Grand Junction; Harold H. Kerr, Pueblo; W. Y. Takahashi, Boulder; Woodrow E. Brown, Paonia; J. Gordon Hedrick, Wray; Martin G. Van Der Schouw, Fort Collins; T. M. Rogers, Sterling; Mark S. Donovan, Wray R. Gardner, George W. Holt, Homer G. McClintock, Karl F. Sunderland and Robert W. Viehe, all of Denver.

Blue Shield Fee Schedule Advisory Committee: Fred A. Humphrey, Fort Collins, Chairman; Lloyd W. Anderson, Sterling; John H. Amesse, Robert F. Bell, George R. Buck, J. Lawrence Campbell, John G. Griffin, John B. Grow, Daniel R. Higbee, Harry C. Hughes, Frank B. McGlone, Douglas W. Macomber, Bradford Murphey, John M. Nelson, James A. Philpott, Kenneth Sawyer, Warren W. Tucker, John I. Zarit, all of Denver; William N. Baker, George A. Unfug, Pueblo; George G. Balderston, Montrose; Lee J. Beuchat, Trinidad; Lawrence D. Buchanan, Wray; Guy E. Calonge, La Junta; Norman L. Currie, Burlington; L. L. Hick, Delta; Paul R. Hildebrand, Brush; Fred D. Kuykendall, Eaton; James M. Lamme, Jr., Walsenburg; Robert C. Lewis, Jr., Aspen; Mason Light, Gunnison; James S. Haley, Longmont; Harlan E. McClure, Lamar; Franklin J. McDonald, Leadville; Ben H. Mayer, Steamboat Springs; Edward G. Merritt, Dolores; G. C. Milligan, Englewood; C. W. Vickers, Del Norte; A. D. Waroshill, Florence; W. Lloyd Wright, Golden; Theodore E. Heinz, Greeley; John D. Gillaspie, Boulder; Kenneth E. Gloss, John W. Bradley, John L. McDonald, R. C. Vanderhoof, all of Colorado Springs, Kenneth E. Prescott, Geno Saccomanno, Grand Junction.

Military Affairs Committee: Robert S. Liggett, Chairman; George R. Buck, John M. Foster, all of Denver; Claude D. Bonham, Boulder; Calvin N. Caldwell, Pueblo; Ward C. Fenton, Rocky Ford; Leo W. Lloyd, Durango; W. B. Crouch, Colorado Springs; Harvey M. Tupper, Grand Junction.

Nursing Education Problems: Harold D. Palmer, Chairman; Kenneth C. Sawyer, E. Paul Sheridan, John R. Evans, Ervin A. Hinds, Samuel P. Newman, Fred H. Good, all of Denver; Russell H. Hanson, Boulder; Harry C. Bryan, Colorado Springs; John J. Yaeger, Pueblo; E. H. Munro, Grand Junction; Richard L. Davis, La Junta.

Organization Study Committee: Lawrence D. Buchanan, Chairman, Wray; Bradford Murphey, Vice Chairman, Denver; John S. Bouslog, Denver; Archer C. Sudan, Grand Junction; William A. Campbell, Colorado Springs; George A. Unfug, Pueblo; Arthur B. Gjellum, Del Norte; John A. Weaver, Greeley; Jackson L. Sadler, Fort Collins.

SPECIAL REPRESENTATIVES

Representative to Rocky Mountain Radio Council: John S. Bouslog, Denver.

Representative to Adult Education Council: John A. Edwards, Denver; Richard B. Greenwood, Denver.

MONTANA MEDICAL ASSOCIATION

NEXT ANNUAL MEETING: BUTTE, SEPTEMBER 16-19, 1954

OFFICERS, 1953-1954

Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated, the term is for one year only and expires at 1954 Annual Session.

President: Sidney C. Pratt, 6 North 7th, Miles City.
President-Elect: J. J. Malee, 101 Main Street, Anaconda.
Vice President: George W. Setzer, Malta.
Secretary-Treasurer: T. R. Vye, 412 North Broadway, Billings.
Assistant Secretary-Treasurer: Park W. Willis, Jr., 215 Main Street, Hamilton.
Executive Secretary: Mr. L. R. Hegland, 1236 N. 28th Street, Billings.
Delegate to American Medical Association: R. F. Peterson, 9 West Granite, Butte.
Alternate Delegate to American Medical Association: Thomas L. Hawkins, 555 Fuller Avenue, Helena.

STANDING COMMITTEES

Executive Committee: S. C. Pratt, Chairman, Miles City; James M. Flinn, Helena; J. J. Malee, Anaconda; Frank L. McPhail, Great Falls; George W. Setzer, Malta; T. R. Vye, Billings; Park W. Willis, Jr., Hamilton.

Economic Committee: D. S. MacKenzie, Jr., Chairman, Havre; Raymond E. Benson, Billings; Leonard W. Brewer, Missoula; Paul J. Gans, Lewistown; David Gregory, Glasgow; William E. Harris, Livingston; Robert J. Holzberger, Great Falls; John E. Low, Sidney.

Legislative Committee: Amos R. Little, Jr., Chairman, Helena; David T. Berg, Helena, 1956; Herbert T. Caraway, Billings, 1955; William F. Cashmore, Helena, 1955; C. H. Fredrickson, Missoula, 1956; M. A. Gold, Butte, 1954; A. M. Lueck, Livingston, 1954.

Necrology and History of Medicine Committee: E. S. Murphy, Chairman, Missoula; R. D. Benson, Sidney; M. G. Danskin, Billings; Albert A. Dodge, Kalispell; E. M. Gans, Harlowton; William G. Richards, Billings; John P. Ritchey, Missoula; James I. Wernham, Billings.

Public Relations Committee: Park W. Willis, Jr., Chairman, Hamilton, 1955; Albert W. Axley, Havre, 1955; E. H. Lindstrom, Helena, 1954; C. S. Meeker, Butte, 1954; C. R. Svore, Missoula, 1956; A. L. Vadheim, Jr., Bozeman, 1956; George D. Waller, Jr., Cut Bank, 1956; M. D. Winter, Miles City, 1954; John A. Whittinghill, Billings, 1955; S. A. Cooney, Helena, Ex-officio.

Legal Affairs and Malpractice Committee: Louis W. Allard, Chairman, Billings; John H. Bridenbaugh, Billings; Fritz D. Hurd, Great Falls; Robert E. Mattison, Billings; Park W. Willis, Jr., Hamilton.

Program Committee: Thomas W. Saam, Chairman, Butte; John A. Layne, Vice-Chairman, Great Falls; Deane C. Epler, Bozeman; Roger A. Larson, Billings; Stephen N. Preston, Missoula; Theodore R. Vye, Billings, Ex-officio.

Interprofessional Relations Committee: George A. Sexton, Chairman, Great Falls; Louis W. Allard, Billings; Richard O. Chambers, Glendive; John K. Colman, Butte; Thomas L. Hawkins, Helena; Francis I. Sabo, Bozeman.

Nominating Committee: C. R. Svore, Chairman, Missoula; M. A. Gold, Butte; Wayne Gordon, Billings; Wyman J. Roberts, Great Falls; William A. Treat, Miles City.

Auditing Committee: George M. Donich, Chairman, Anaconda; Leonard M. Benjamin, Deer Lodge; Robert D. Knapp, Wolf Point; John J. Mitschke, Helena; George G. Sale, Missoula.

Mediation Committee: Frederic S. Marks, Chairman, Billings, 1954; H. M. Clemmons, Butte, 1955; Harold W. Fuller, Great Falls, 1956; Ezner P. Higgins, Kalispell, 1954; Chester W. Lawson, Havre, 1955; James J. McCabe, Helena, 1954; George J. Moffitt, Livingston, 1956; E. S. Murphy, Missoula, 1955; R. W. Polk, Miles City, 1956.

Cancer Committee: Harold W. Gregg, Chairman, Butte; Walter B. Cox, Missoula; Deane C. Epler, Bozeman; Chester W. Lawson, Havre; Stuart A. Olson, Glendive; Philip D. Pallister, Boulder; Edwin C. Segard, Billings.

Maternal and Child Welfare Committee: Earl L. Hall, Chairman, Great Falls.

Subcommittee on Obstetrics: Glenn A. Carmichael, Chairman, Missoula; J. E. Brann, Kalispell; Harry B. Campbell, Missoula; Maude M. Gerdes, Billings; Elna M. Howard, Miles City; Charles W. Pemberton, Butte.

Subcommittee on Pediatrics: Donald L. Gillespie, Chairman, Butte; George H. Barmeyer, Missoula; Roger W. Clapp, Butte; Frank J. Friden, Great Falls; Harry J. Lawler, Billings; Orville M. Moore, Helena; R. Wynne Morris, Helena; George W. Nelson, Billings; Philip D. Pallister, Boulder; Paul R. Ensign, Helena, Ex-officio.

Tuberculosis Committee: Harry V. Gibson, Chairman, Great Falls; Malcolm O. Burns, Kalispell; Roger W. Clapp, Butte; H. M. Clemmons, Butte; Alfred M. Fulton, Billings; Donald D. Goose, Missoula; John M. Nelson, Missoula; Frank M. Petkevich, Great Falls; Frank I. Terrill, Galen; L. S. McLean, Helena, Ex-officio.

Fracture and Orthopedic Committee: John C. Wolgamot, Chairman, Great Falls; L. Clayton Allard, Billings; Louis W. Allard, Billings; H. M. Clemmons, Butte; John K. Colman, Butte; Walter H. Hagen, Billings; Charles F. Honeycutt, Missoula; Stephen L. Odgers, Missoula; Paul R. Ensign, Helena, Ex-officio.

Rural Health Committee: B. C. Farrand, Chairman, Jordan; Henry J. Borge, Wolf Point; Charles P. Brooke, Missoula; David Gregory, Glasgow; Raymond G. Johnson, Harlowton; B. K. Kilbourne, Hardin; Ronald E. Losee, Ennis; Walter G. Tanglin, Polson; George E. Trobough, Anaconda; L. S. McLean, Helena, Ex-officio.

Industrial Welfare Committee: Russell B. Richardson, Chairman, Great Falls; David J. Almas, Havre; Theodore W. Cooney, Helena A. R. Kintner, Missoula; William F. Morrison, Missoula; L. F. Rotar, Butte; James G. Sawyer, Butte; Paul J. Sullivan, Billings; Frank K. Waniata, Great Falls; G. D. Carlyle Thompson, Helena, Ex-officio.

Rheumatic Fever and Heart Committee: F. R. Schemm, Chairman, Great Falls; Deane C. Epler, Bozeman; John S. Gilson, Great Falls; M. A. Gold, Butte; Elizabeth Grimm, Billings; B. A. Lucking, Helena; Harold E. McIntyre, Billings; C. S. Meeker, Butte; Orville M. Moore, Helena; Richard D. Weber, Missoula; G. D. Carlyle Thompson, Helena, Ex-officio.

Rocky Mountain Medical Conference Committee: Herbert T. Caraway, Chairman, Billings, 1954; H. M. Blegen, Missoula, 1955; Charles B. Craft, Bozeman, 1956; M. A. Gold, Butte, 1958; Frank K. Waniata, Great Falls, 1957; Sidney C. Pratt, Miles City, Ex-officio; Theodore R. Vye, Billings, Ex-officio.

Public Health Committee: J. J. Malee, Chairman, Anaconda; B. C. Farrand, Jordan; Harry V. Gibson, Great Falls; Harold W. Gregg, Butte; Earl L. Hall, Great Falls; A. R. Kintner, Missoula; Raymond F. Peterson, Butte; R. B. Richardson, Great Falls; Ferdinand R. Schemm, Great Falls; John W. Schubert, Lewistown; George A. Sexton, Great Falls; Walter G. Tanglin, Polson; Thomas F. Walker, Jr., Great Falls; Winfield S. Wilder, Great Falls; John C. Wolgamot, Great Falls.

Hospital Relations Committee: Raymond F. Peterson, Chairman, Butte; Walter B. Cox, Missoula; Thomas L. Hawkins, Helena; William W. McLaughlin, Great Falls; Francis P. Nash, Townsend; Stuart A. Olson, Glendive; Grant P. Raitt, Billings; Edwin C. Segard, Billings.

SPECIAL COMMITTEES

Arthritis and Rheumatism Committee: Ralph H. Biehn, Chairman, Billings; Betty S. Gibson, Great Falls; A. R. Kintner, Missoula; Thomas F. Walker, Jr., Great Falls; M. D. Winter, Miles City.

Committee on Blood Banks: Mary E. Martin, Chairman, Billings; H. M. Blegen, Missoula; William W. McLaughlin, Great Falls; Raymond F. Peterson, Butte.

Emergency Medical Service Committee: John W. Schubert, Chairman, Lewistown; J. H. Brancamp, Butte; T. D. Callan, Anaconda; John C. Hanley, Great Falls; Harrison D. Huggins, Kalispell; A. J. Marchello, Billings; George G. Sale, Missoula; Stuart D. Whetstone, Cut Bank; G. D. Carlyle Thompson, Helena, Ex-officio.

Committee on Medical Education: Everett H. Lindstrom, Chairman, Helena; Leonard W. Brewer, Missoula; L. L. Howard, Great Falls; Frank L. McPhail, Great Falls; James D. Morrison, Billings.

Mental Hygiene Committee: Winfield S. Wilder, Chairman, Great Falls; Joseph W. Brinkley, Great Falls; James J. Bulger, Great Falls; Gladys V. Holmes, Missoula; M. A. Ruona, Billings.

School Health Committee: Ray O. Bjork, Chairman, Helena; George M. Donich, Anaconda; David F. Hall, Butte; Earl L. Hall, Great Falls; E. P. Higgins, Kalispell; Chester W. Lawson, Havre; Stuart A. Olson, Glendive; C. R. Svore, Missoula.

Committee on Veterans Affairs: C. H. Fredrickson, Chairman, Missoula; Malcolmn O. Burns, Kalispell; Fritz D. Hurd, Great Falls; John E. Hynes, Billings; Ray O. Lewis, Helena; Raymond F. Peterson, Butte.

Advisory Committee on Courses for Medical Secretaryships: David J. Almas, Chairman, Havre; E. K. George, Missoula; Edward W. Gibbs, Billings; Herbert H. James, Butte; Ronald G. Keeton, Bozeman; Otto G. Klein, Helena; Neil M. Leitch, Kalispell; George B. LeTellier, Lewistown; Frank K. Waniata, Great Falls.

REPRESENTATIVES OF MONTANA MEDICAL ASSOCIATION TO OTHER STATE AND NATIONAL ORGANIZATIONS

Montana Committee for Employment of Physically Handicapped: Stephen L. Odgers, Missoula.

Joint Committee of Health Problems in Education of the National Education Association and the American Medical Association: Ray O. Bjork, Helena.

State Committee for Student Affiliation in the Field of Public Health: L. S. McLean, Helena.

State Board of Eugenics: Gladys V. Holmes, Missoula; Sidney C. Pratt, Miles City.

Montana Health Planning Council: Park W. Willis, Jr., Hamilton; Walter G. Tanglin, Polson.

American Medical Education Foundation: Chester W. Lawson, Havre, Chairman for Montana.

Advisory Committee on Narcotic and Alcohol Education: Theodore W. Cooney, Helena; Winfield S. Wilder, Great Falls.

Rocky Mountain Medical Journal: Raymond F. Peterson, Butte, Scientific Editor for Montana; Mr. L. R. Hegland, Associate Editor for Montana.

For the Peptic Ulcer Patient

BEDEVILED BY NIGHT PAIN

AMPHOJEL®

ALUMINUM HYDROXIDE GEL

AMPHOJEL helps patients sleep by neutralizing acid promptly . . . promoting pain relief through the night. A double dose at bedtime will effectively control "night pain" in most patients.

AMPHOJEL is a double gel—one *reactive*, for immediate buffering of gastric acid; the other, *demulcent*, for prolonged coating of the gastric mucosa—protection for the granulation tissue in the ulcer crater.

Wyeth®
Philadelphia 2, Pa.

Available: Suspension: Bottles of 12 fl. oz.
Tablets: Boxes of 30 (5 gr.), bottles of 100
Boxes of 60 (10 gr.)

NEW MEXICO MEDICAL SOCIETY

NEXT ANNUAL SESSION: SANTA FE, MAY 13, 14, 15, 1954

OFFICERS—1953-54

President: Albert S. Lathrop, Santa Fe.

President-Elect: John P. Conway, Clovis.

Vice President: Stuart W. Adler, Albuquerque.

Secretary-Treasurer: T. E. Kircher, Jr., Albuquerque.

Executive Secretary: Mr. Ralph R. Marshall, 223-24 First National Bank Building, Albuquerque.

Councilors (three years): Carl H. Gellenthien, Valmora; R. C. Derbyshire, Santa Fe; (two years): Carl Mulky, Albuquerque; J. C. Sedgwick, Las Cruces; (one year): W. D. Ilabbs, Clovis; W. E. Badger, Hobbs.

Delegate to American Medical Association (two years): Carl H. Gellenthien, Valmora; Alternate, H. L. January, Albuquerque.

COMMITTEES—1953-54

Board of Trustees, New Mexico Physicians' Service: President: John F. Conway, Clovis; Vice President, V. K. Adams, Raton; Secretary-Treasurer L.G. Rice, Jr., Albuquerque; A. H. Follingstad, Albuquerque; C. H. Gellenthien, Valmora; H. L. January, Albuquerque; A. S. Lathrop, Santa Fe; I. J. Marshall, Roswell; W. A. Stark, Las Vegas, L. J. Whitaker, Deming; C. L. Womack, Carlsbad; Mr. L. J. Lagrave, Executive Director, 212 Insurance Building, Albuquerque.

Board of Supervisors (one year): Leland S. Evans, Las Cruces; Charles M. Thompson, Albuquerque; Clay Gwinn, Carlsbad; Victor E. Berchtold, Santa Fe; (two years): Earl L. Malone, Roswell; Milton Floersheim, Raton; George Prothro, Clovis; N. D. Frazin, Silver City.

Basic Science Committee: Bergere A. Kenney, Santa Fe, Chairman; Harold J. Beck, Albuquerque; Junius A. Evans, Las Vegas.

Consulting Committee to State Department of Public Health: Carl B. Gellenthien, Valmora; Lewis M. Overton, Albuquerque; A. W. Egenhofer, Santa Fe; Robert R. Boice, Roswell; L. C. Delambre, Albuquerque.

Infancy and Maternal Care Committee: Allen C. Service, Roswell, Chairman; G. C. Hogsett, Carlsbad; Guy E. Rader, Albuquerque; Herbert B. Ellis, Santa Fe; Marion Hotopp, Santa Fe; J. W. Wiggins, Albuquerque; W. L. Minton, Lovington.

Indigent Medical Care Committee: Samuel R. Ziegler, M.D., Espanola, Chairman; E. W. Lander, M.D., 211 W 3rd St., Roswell; R. E. Forbis, M.D., Medical Arts Sq., Albuquerque.

Public Relations Committee: M. J. Smith, M.D., Coronado Bldg., Santa Fe, Chairman; Randolph V. Seligman, M.D., Medical Arts Square, Albuquerque; Earl L. Malone, M.D., 302 W. Tilden, Roswell; Junius A. Evans, M.D., 1032 7th St., Las Vegas; D. D. Lancaster, M.D., Box 569, Portales.

Rocky Mountain Medical Conference: Carl H. Gellenthien, M.D., Valmora, Chairman; J. W. Beattie, M.D., 608 University Ave., Las Vegas; Eric P. Hausner, M.D., Coronado Bldg., Santa Fe.

Committee on Selective Service: H. L. January, M.D., Lovelace Clinic, Albuquerque, Chairman; Philip L. Travers, M.D., Coronado Bldg., Santa Fe; George S. Morrison, M.D., 113 S. Kentucky, Roswell.

Advisory Committee on Insurance Compensation: Gerald A. Slusser, Artesia; Pete J. Starr, Artesia; Robert C. Boice, Roswell.

Legislative and Public Policy Committee: R. C. Derbyshire, Santa Fe, Chairman; R. P. Beaudette, Raton; Joel Zeigler, Clovis; L. L. Daviet, Las Cruces; E. M. Warner, Tucumcari; W. E. Oakes, Los Alamos; Louis F. Hamilton, Artesia; W. L. Minear, Truth or Consequences; R. E. Watts, Silver City; Ashley Pond, Taos; H. W. Hodde, Hobbs; W. J. Hosley, Deming; I. J. Marshall, Roswell; W. O. Connor, Jr., Albuquerque; Albert Simms, II, Albuquerque; Clay Gwinn, Carlsbad; Marcus J. Smith, Santa Fe; W. A. Stark, Las Vegas; Leland S. Evans, Las Cruces.

National Emergency Medical Service Committee: Roy R. Robertson, Albuquerque, Chairman; Brian S. Moynahan, Santa Fe; T. E. Kircher, Jr., Albuquerque.

How to control itching and scaling for **1** *to* **4** *weeks*

You can expect results like these with SELSUN: complete control in 81 to 87 per cent of all seborrheic dermatitis cases, and in 92 to 95 per cent of common dandruff cases. SELSUN keeps the scalp free of scales for *one to four weeks*—relieves itching and burning after only two or three applications.

Your patients just add SELSUN to their regular hair-washing routine. No messy ointments . . . no bedtime rituals . . . no disagreeable odors. SELSUN leaves the hair and scalp clean and easy to manage.

Available in 4-fluidounce bottles, SELSUN is ethically promoted and dispensed only on your prescription. Abbott

prescribe

SELSUN®

Sulfide Suspension

(*Selenium Sulfide, Abbott*)

1-182-54

THE UTAH STATE MEDICAL ASSOCIATION

NEXT ANNUAL SESSION: OGDEN, MAY 26-28, 1954

OFFICERS, 1953-1954

President: Frank K. Bartlett, Ogden.

President-Elect: Charles Ruggeri, Salt Lake City.

Past President: K. B. Castleton, Salt Lake City.

Honorary President: L. S. Merrill, Hiawatha.

Secretary: Homer E. Smith, Salt Lake City.

Executive Secretary: Mr. Harold Bowman, Salt Lake City.

Treasurer: J. R. Miller, Salt Lake City.

Councilor, Cache Valley Medical Society: R. O. Porter, Logan.

Councilor, Carbon County Medical Society: J. Eldon Dorman, Price.

Councilor, Central Utah Medical Society: R. N. Malouf, Richfield.

Councilor, Salt Lake County Medical Society: V. L. Rees, Salt Lake City.

Councilor, Southern Utah Medical Society: R. G. Williams, Cedar City.

Councilor, Uintah Basin Medical Society: T. R. Seager, Vernal.

Councilor, Utah County Medical Society: D. E. Ostler, Provo.

Councilor, Weber County Medical Society: Rich Johnston, Ogden.

Delegate to A.M.A., 1954 and 1955: Geo. M. Fister, Ogden.

Alternate Delegate to A.M.A., 1954 and 1955: Eliot Snow, Salt Lake City.

Editor of the Utah Section of the Rocky Mountain Medical Journal: R. P. Middleton, Salt Lake City.

Board of Supervisors: 1954, J. C. Hubbard, Price; 1955, J. G. Olson, Ogden; 1956, C. J. Daines, Logan; 1957, R. E. Jorgenson, Provo.

STANDING COMMITTEES

Rocky Mountain Medical Conference Continuing Committee: 1954, R. P. Middleton, Chairman, Salt Lake City; 1955, U. R. Bryner, Salt Lake City; 1956, Heber C. Hancock, Ogden; 1957, Wm. H. Morets, Salt Lake City; 1958, Robert G. Snow, Salt Lake City.

Scientific Program Committee: Homer E. Smith, Chairman, Salt Lake City.

Medical Defense Committee: 1954, Fuller Bailey, Salt Lake City; 1954, Reed Harrow, Salt Lake City; 1954, H. R. Reichman, Salt Lake City; 1955, Wm. M. Nebeker, Chairman, Salt Lake City; 1955, G. S. Francis, Wellsville; 1955, Donald V. Poppen, Provo; 1956, Paul K. Edmunds, Cedar City; 1956, Oscar Ernest Grun, Ogden.

Medical Education and Hospitals Committee: 1954, Harry J. Brown, Chairman, Provo; 1954, L. K. Gates, Logan; 1954, K. A. Crockett, Salt Lake City; 1955, R. V. Larsen, Roosevelt; 1955, Mark B. Jensen, Castle Gate; 1955, J. B. Cluff, Richfield; 1955, W. J. Reichman, St. George; 1956, E. D. Zeman, Ogden; 1956, P. M. Gonzales, Price; 1957, E. G. Holmstrom, Salt Lake City; 1957, Philip Price, Salt Lake City; 1957, John A. Gubler, Salt Lake City.

Medical Economics Committee: 1954, Geo. C. Ficklin, Tremonton; 1954, J. H. Millburn, Toole; 1955, Ralph N. Barlow, Chairman, Logan; 1955, Thomas R. Broadbent, Salt Lake City; 1955, A. W. Middleton, Salt Lake City.

Procurement and Assignment Committee: Eliot Snow, Chairman, Salt Lake City; Frank K. Bartlett, Ogden; John J. Galligan, Salt Lake City; John H. Clark, Salt Lake City; J. Russell Smith, Provo.

SPECIAL COMMITTEES ALLIED TO PUBLIC HEALTH

General Committee on Public Health: Frank J. Winget, Chairman, Salt Lake City; C. H. H. Branch, Salt Lake City; Geo. H. Curtis, Salt Lake City; Robt. S. Rothwell, Salt Lake City; Glen R. Leymaster, Salt Lake City; Nephi K. Kezerian, Provo; Ralph C. Ellis, Ogden; R. W. Farnsworth, Cedar City.

Committee on Fractures: Nephi K. Kezerian, Chairman, Provo; Wallace E. Hem, Salt Lake City; Chas. M. Swindler, Ogden.

Cancer Committee: Ralph C. Ellis, Chairman, Ogden; H. B. Fowler, Vernal; Geo. W. Gasser, Logan; Shelley A. Swift, Salt Lake City; David Garth Edmunds, Salina

Committee on Sewage, Water and Air Pollution: Glenn R. Leymaster, Chairman, Salt Lake City; Chas. M. Smith, Provo; John Smith, Duchesne; G. S. Rees, Gunnison; Russell N. Hirst, Ogden; J. Clair Hayward, Logan; Quinn Whiting, Price; J. S. Prestwich, Cedar City.

Committee on Tuberculosis and Cardio Vascular Diseases: George N. Curtis, Chairman, Salt Lake City; Keith Farr, Ogden; Merrill C. Daines, Logan; L. Wayland Macfarlane, Salt Lake City; C. W. Sorenson, Salt Lake City.

Committee on Rural Health: R. W. Farnsworth, Chairman, Cedar City; J. Howard Rasmussen, Co-Chairman, Brigham City; Paul G. Stringham, Roosevelt; Milo C. Moody, Spanish Fork; Kurt L. Jenkins, Marysvale;

Committee on School Health: Robert S. Rothwell, Chairman, Salt Lake City; R. W. Sonntag, Salt Lake City; Geo. B. Ely, Salt Lake City; Roy A. Darke, Salt Lake City; Grant H. Way, Ogden; Roy B. Hammond, Provo; Jane Fowler, Vernal.

Committee on Mental Health: Chas. H. Branch, Chairman, Salt Lake City; L. G. Moench, Salt Lake City; E. M. Kilpatrick, Salt Lake City; Owen P. Heninger, Provo; Wm. D. O'Gorman, Ogden.

Industrial Health Committee: Frank J. Winget, Chairman, Salt Lake City; Geo. A. Spendlove, Salt Lake City; Paul S. Richards, Salt Lake City; Byron Daynes, Salt Lake City; Ralph Tingey, Salt Lake City; L. H. Merhill, Hiawatha; H. C. Jenkins, Bingham Canyon, Rulon Howe, Ogden.

SPECIAL COMMITTEES ALLIED TO PUBLIC RELATIONS

General Committee on Public Relations: James Z. Davis, Chairman, Salt Lake City; Drew Peterson, Ogden; Wallace Brooke, Salt Lake City; Fred W. Clausen, Salt Lake City; R. P. Middleton, Salt Lake City.

Legislative Committee: James Z. Davis, Chairman, Salt Lake City; Dean C. Evans, Fillmore; R. M. Muirhead, Salt Lake City; John Z. Bowers, Salt Lake City; Geo. A. Spendlove, Salt Lake City; L. V. Broadbent, Cedar City; P. M. Gonzales, Helper; J. G. McQuarrie, Richfield; Ray E. Spendlove, Vernal; Eugene L. Wiemers, Pleasant Grove; Robert Budge, Smithfield; Clark Rich, Ogden.

Committee on Utah Health Council: Drew Peterson, Ogden; N. F. Hicken, Salt Lake City; L. E. Viko, Salt Lake City; H. R. Reichman, Salt Lake City; K. B. Castleton, Ex-Officio, Salt Lake City; Paul Clayton, Salt Lake City.

Committee on Relations With Press, Radio and Television: Wallace Brooke, Chairman, Salt Lake City; Donald Moore, Ogden; R. H. Wakefield, Provo; J. Clair Hayward, Logan; L. H. Merrill, Hiawatha; Irving Ershler, Salt Lake City.

Committee on Insurance Plans: Fred W. Clausen, Chairman, Salt Lake City; John Z. Brown, Jr., Salt Lake City; Robt. D. Beech, Salt Lake City; Robert G. Snow, Salt Lake City; John H. Clark, Salt Lake City; Clair Hayward, Logan.

Newspaper Health Column Committee: R. P. Middleton, Chairman, Salt Lake City; Edwin Zeman, Ogden; L. W. Oaks, Provo; T. C. Bauerlein, Salt Lake City; W. H. Morets, Salt Lake City; M. E. Bird, Delta.

SPECIAL COMMITTEES

Civilian Defense Committee: Leslie J. Paul, Chairman, Salt Lake City; S. M. Budge, Logan; LeRoy A. Wirthlin, Salt Lake City; L. W. Benson, Ogden; Riley G. Clark, Provo; Geo. Spendlove, Salt Lake City.

Constitution and By-Laws Committee: J. Russell Smith, Chairman, Provo; James M. Catlin, Ogden; W. W. Barrett, Helper; R. O. Johnson, Murray; Garner B. Meads, Salt Lake City; Heber Hancock, Ogden; James Cleary, Salt Lake City.

Fee Schedule Committee: Wm. Ray Rumel, Chairman, Salt Lake City.

Blood Bank Committee: M. W. Wintrobe, Chairman, Salt Lake City. Plus the chairman of the Blood Bank Committee of each Component Society.

Advisory Committee to Woman's Auxiliary: Frank K. Bartlett, Chairman, Ogden; Charles Ruggeri, Salt Lake City; K. B. Castleton, Salt Lake City; Homer E. Smith, Salt Lake City; J. R. Miller, Salt Lake City; R. O. Porter, Logan; J. Eldon Dorman, Price; R. N. Malouf, Richfield; V. L. Rees, Salt Lake City; R. G. Williams, Cedar City; T. R. Seager, Vernal; D. E. Ostler, Provo; Rich Johnston, Ogden.

Necrology Committee: James K. Palmer, Salt Lake City.

Labor Relations Committee: V. L. Rees, Chairman, Salt Lake City; James McClintock, Dragerton; A. L. Graff, Cedar City; Quinn Whiting, Price; Frank K. Winget, Salt Lake City; E. M. Kilpatrick, Salt Lake City; Rulon M. Howe, Ogden; Boyd J. Larson, Lehi.

Rheumatic Fever Committee: E. M. Kilpatrick, Chairman, Salt Lake City; Stanley Child, Salt Lake City; Homer Rich, Ogden; L. E. Viko, Salt Lake City; Geo. Spendlove, Salt Lake City; R. W. Farnsworth, Cedar City; W. E. Peitzer, Salt Lake City.

Veterans Affairs Committee: Vernon Stevenson, Chairman, Salt Lake City; Vernal H. Johnson, Ogden; John H. Rupper, Provo.

Special Liaison Committee to Allied Professions: Charles Ruggeri, Chairman, Salt Lake City; Wm. M. Nebeker, Salt Lake City; T. C. Weggeland, Salt Lake City; Eugene Wood, Salt Lake City; Dean Tanner, Ogden.

Committee on Aid to the Aged: V. L. Ward, Chairman, Ogden; J. J. Weight, Provo; A. J. Lund, Ogden; Victor Kassell, Salt Lake City; T. R. Gledhill, Richfield; L. W. Sorenson, Parowan; D. T. Madsen, Price.

Committee on Accident Prevention: W. H. Anderson, Chairman, Ogden; J. P. Bartlett, Ogden; Ralph N. Barlow, Logan; W. Ezra Cragun, Logan; W. R. Young, Salt Lake City; Nomma Randall, Salt Lake City; Leonard H. Taboroff, Salt Lake City; Joseph P. Kesler, Salt Lake City; A. M. Okelberry, Salt Lake City; Woodrow Nelson, Salt Lake City; R. H. Wakefield, Provo; M. K. McGregor, St. George; Tyrell R. Seager, Vernal; R. N. Malouf, Richfield; Eugene Davis, Milford; E. S. McQuarrie, Beaver.

Among the Potent Hypotensives

Noteworthy for its SAFETY

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Veriloid®

A selective alkaloidal extract (alkavervir fraction) of Veratrum viride, Veriloid presents these noteworthy features when a potent hypotensive agent is indicated. Its dosage forms provide notable flexibility in treatment.

- Biologic assay—based on actual blood pressure reduction in mammals—assures uniform potency and constant pharmacologic action.
- Blood pressure is lowered by centrally mediated action; there is no ganglionic or adrenergic blocking.
- Therapy is rarely, if ever, fraught with the danger of postural hypotension.
- Hypotensive action is independent of alterations in heart rate.
- Cardiac output is not reduced.
- Renal function, unless previously grossly reduced, is not compromised.
- Cerebral blood flow is not decreased.
- Cardiac work is not increased, tachycardia is not engendered.
- No dangerous toxic effects from oral administration, no deaths attributable to Veriloid have ever been reported. Side actions of diarrhea, substernal burning, bradycardia, nausea, and vomiting (due to overdosage) are readily overcome and thereafter avoided by dosage adjustment.
- In broad use over five years, literally in hundreds of thousands of patients, no other sequelae have been reported, whether Veriloid is given orally or parenterally.
- Tolerance or idiosyncrasy rarely develops; allergic reactions have not been encountered. Hence tablets Veriloid can be given for the long course of treatment required in severe hypertension.
- Continuing therapy with Veriloid has not led to interference with appetite or with excretory function.
- Because of its rapidly induced, prolonged action (6 to 8 hours), tablets Veriloid provide around-the-clock hypotensive effect from 4 doses daily, make today's dosage effective today, and usually prevent hypertensive "spiking" during the night.
- A notable safety factor in intravenous administration is: *the extent to which blood pressure is lowered is directly within the control of the physician.*

Tablets

Slow-dissolving, scored tablets in 2 mg. and 3 mg. potencies; produce gratifying response in many patients with moderate to severe hypertension; in fully 30% of patients this response can be maintained for long periods;[1] combination with other hypotensive agents greatly increases this percentage.[2] Initially, 9 mg. daily, in divided doses, not less than 4 hours apart, preferably after meals. Dosage to be increased gradually, by small increments, till maximum tolerated dose is reached. Maintenance dose, 9 to 24 mg. daily.

Solution Intravenous

For immediate reduction of critically elevated blood pressure in hypertensive emergencies such as hypertensive states accompanying cerebral vascular disease, hypertensive crisis (encephalopathy), toxemias of pregnancy; lowers blood pressure promptly, to any degree the physician desires, and with notable safety, since excessive hypotensive and bradycardic effects are readily overcome by simple means. Supplied in a combination package containing one 5 cc. ampul and a 20 cc. vial of diluent, and in boxes of six 5 cc. ampuls. Solution contains 0.4 mg. Veriloid per cc.

Solution Intramuscular

For maintenance of blood pressure in such critical instances, and for primary use in less critical situations not showing the same immediate urgency. Provides 1.0 mg. Veriloid per cc. in isotonic aqueous solution incorporating one per cent procaine hydrochloride. A single dose lowers blood pressure significantly, reaching maximum hypotensive effect in 60 to 90 minutes. By repeated injections (every 3 to 6 hours) blood pressure may be kept depressed for hours or days if necessary. In boxes of six 2 cc. ampuls. Complete instructions (dosage and administration) with every ampul of the parenteral preparations should be noted carefully.

1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (Veratrum Viride), Lancet 2:1002 (Dec. 1) 1951.
2. Wilkins, R.W.: Combination of Drugs in the Treatment of Essential Hypertension, Mississippi Doctor *30*:359 (Apr.) 1953.

ORIGINAL RESEARCH PRODUCTS OF

RIKER LABORATORIES, INC. 8480 Beverly Boulevard, Los Angeles 48, California

THE WYOMING STATE MEDICAL SOCIETY

NEXT ANNUAL SESSION: SHERIDAN, JUNE 7, 8, AND 9, 1954

OFFICERS

President: James W. Sampson, Sheridan.
President-elect: R. J. Sullivan, Laramie.
Vice President: Nels Vicklund, Thermopolis.
Secretary: Royce D. Tebbet, Casper.
Treasurer: C. L. Rogers, Sheridan.
Delegate to A.M.A.: W. Andrew Bunten, 1953, Cheyenne.
Alternate-Delegate to A.M.A.: Albert T. Sudman, 1953, Green River.
Executive Secretary: Arthur R. Abbey, Cheyenne.

Councillors: Paul R. Holtz, Chairman, 1955, Lander; Earl Whedon, 1955, Sheridan; Karl E. Krueger, 1954, Rock Springs; George H. Phelps, 1954, Cheyenne; Joseph Whalen, 1956, Evanston; J. Cedric Jones, 1956, Cody; Glen O. Beach, 1956, Casper; Ex-Officio: James W. Sampson, President, Sheridan; Royce D. Tebbet, Secretary, Casper.

COMMITTEES

Public Relations Committee: Nels Vicklund, Chairman, Thermopolis; Members—All County Medical Society Presidents.

Committee for Professional Review: J. Cedric Jones, Chairman, 1955, Cody; Roscoe H. Reeve, 1955, Casper; David Flett, 1954, Cheyenne; Albert Sudman, 1956, Green River.

Elected Medical Defense Committee: Karl E. Krueger, Chairman, 1954, Rock Springs; Paul R. Holtz, 1955, Lander; Ed Guilfoyle, 1956, Newcastle.

Advisory Committee to Selective Service on Procurement and Assignment of Physicians: Sam Zuckerman, Chairman, 1955, Cheyenne; Roscoe H. Reeve, 1954, Casper; Joseph A. Gautsch, 1956, Cody.

Veterans Affairs and Military Service Committee: Louis G. Booth, Chairman, Sheridan; (Members to be assigned at a later date).

Blue Cross Hospital Committee: Russel Williams, Chairman, 1954, Cheyenne; Roscoe H. Reeve, 1955, Casper; DeWitt Dominick, 1956, Cody; L. H. Wilmoth, 1957, Lander.

Blue Shield Committee: G. W. Koford, Chairman, Cheyenne; H. E. Stuckenhoff, Casper; K. L. McShane, Cheyenne; J. Cedric Jones, Cody.

Medical Economics Committee: Carelton D. Anton, Chairman, Sheridan; Nels Vicklund, Thermopolis; A. J. Allegretti, Cheyenne; E. E. Pelton, Laramie.

Rocky Mountain Medical Conference: H. L. Harvey, Chairman, 1954, Casper; Earl Whedon, 1955, Sheridan; George H. Phelps, 1955, Cheyenne; Don MacLeod, 1956, Jackson.

Advisory Committee to Woman's Auxiliary: Ed J. Guilfoyle Chairman, Newcastle; J. E. Clark, Casper; W. H. Pennoyer, Cheyenne.

Public Policy and Legislation: DeWitt Dominick, Chairman, 1956, Cody; G. W. Koford, 1955, Cheyenne; George H. Phelps, 1954, Cheyenne; E. W. DeKay, 1955, Laramie; L. H. Wilmoth, 1954, Lander; C. D. Anton, 1956, Sheridan; E. W. Gardner, 1956, Douglas.

State Institutions Advisory Committee: Joseph F. Whalen, Chairman, Evanston; Franklin D. Yoder, Cheyenne; R. H. Knable, Basin; C. W. Jeffrey, Rawlins; L. H. Wilmoth, Lander.

Council on National Emergency Medical Service Civil Defense: George H. Phelps, Chairman, 1955, Cheyenne; Roscoe H. Reeve, 1955, Casper; E. W. DeKay, 1954, Laramie; P. M. Schunk, 1954, Sheridan; Barnard Stack, 1956, Riverton; Richard Stratton, 1956, Green River; Benjamin Gitlitz, 1956, Thermopolis.

Judicial and Advisory Committee (Workmen's Compensation): District No. 1, George H. Phelps, 1955, Cheyenne; Paul J. Preston, 1956, Cheyenne; K. N. Petri, 1956, Laramie; District No. 2, Karl Krueger, 1954, Rock Springs; District No. 3, John H. Waters, 1954, Evanston; District No. 4, Curtis L. Rogers, 1955, Sheridan; District No. 5, G. M. Groshart, 1954, Worland; District No. 6, O. E. Torkelson, 1956, Lusk; District No. 7, F. H. Haigler, Chairman, 1955, Casper.

American Medical Education Foundation: J. Cedric Jones, Chairman, 1955, Cody; B. J. Sullivan, 1954, Laramie; Glen O. Beach, 1956, Casper.

Necrology Committee: Earl Whedon, Chairman, Sheridan; Franklin D. Yoder, Cheyenne.

Public Health-Liaison Committee: E. Chester Ridgway, Chairman, Cody; H. B. Rae, Torrington; Dale Ashbaugh, Riverton; Guy M. Halsey, Rawlins.

Maternal Welfare: L. D. Kattenhorn, Chairman, Powell; L. H. Wilmoth, Lander; E. D. Kunckel, Casper; G. W. Koford, Cheyenne; W. M. Frans, Newcastle; O. J. Rojo, Sheridan.

Child Health Committee: Lawrence J. Cohen, Chairman, Cheyenne; Lucile B. Kirtland, Monarch; O. K. Scott, Casper; L. F. Allison, Powell.

Syphilis Committee: L. H. Wilmoth, Chairman, Lander; Benjamin Gitlitz, Thermopolis; F. H. Haigler, Casper.

Cancer Committee: Joseph A. Gantsch, Chairman, 1956, Cody; Karl Krueger, 1954, Rock Springs; John Gramlich, 1955, Cheyenne; Dan B. Greer, 1954, Cheyenne; Franklin D. Yoder, 1954, Cheyenne; Charles R. Lowe, 1956, Casper.

Mental Health Committee: Don W. Herrold, Chairman, Cheyenne; Joseph Whalen, Evanston; Benjamin Gitlitz, Thermopolis; William E. Rosene, Wheatland.

Fracture and Industrial Health: Paul J. Preston, Chairman, Cheyenne; H. B. Anderson, Casper; J. S. Hellewell, Evanston.

Rural Health Committee: W. Andrew Bunten, Chairman, Cheyenne; E. F. Noyes, Dixon; O. L. Treloar, Afton, J. E. Hoadley, Gillette.

Gottsche Estate: Franklin D. Yoder, Chairman, Cheyenne; E. W. Gardner, Douglas; O. K. Scott, Casper; Nels Vicklund, Thermopolis; L. H. Wilmoth, Lander; Karl Krueger, Rock Springs.

Advisory to the Easter Seals Committee: Gordon Whiston, Chairman, Casper; O. K. Scott, Casper; S. S. Zuckerman, Cheyenne; J. A. Gautsch, Cody; David Flett, Cheyenne.

Poliomyelitis Committee: L. J. Cohen, Chairman, Cheyenne; O. K. Scott, Casper; Franklin D. Yoder, Cheyenne; Harlan B. Anderson, Casper.

Credentials Committee: Royce D. Tebbet, Chairman, Casper; Curtis L. Rogers, Sheridan; Nels Vicklund, Thermopolis.

Time and Place Committee: B. J. Sullivan, Chairman, Cheyenne; Chairman of Delegation from Northwestern Society; Chairman of Delegation from Natrona County; Chairman of Delegation from Sweetwater County; Chairman of Delegation from Goshen County.

Resolutions Committee: Chairman of the Council, Chairman; Chairman of the Delegation from Laramie County; Chairman of the Delegation from Unita County; Chairman of the Delegation from Northeastern Society; Chairman of the Delegation from Sheridan County.

Nominating Committee: President, Chairman; Past Presidents; Chairman of Delegation from Albany County; Chairman of the Delegation from Carbon County; Chairman of the Delegation from Converse County.

COLORADO HOSPITAL ASSOCIATION

OFFICERS

President: Mr. Elton A. Reese, Alamosa Community Hospital, Alamosa.

President-Elect: To be appointed.

Vice President: Mr. Charles K. LeVine, Beth Israel Hospital, Denver.

Treasurer: M. A. Moritz, Denver General Hospital, Denver.

Acting Executive Secretary: R. A. Pontow, University of Colorado Medical Center, Denver.

Trustees: DeMoss Taliaferro, Children's Hospital, Denver (1954); C. Franklin Fielden, Jr., Memorial Hospital, Colorado Springs (1954); to be appointed (1954); Henry H. Hill, Weld County Hospital, Greeley (1955); John Peterson, Larimer County Hospital, Ft. Collins (1955); Hubert Hughes, General Rose Memorial Hospital, Denver (1955); R. A. Pontow, University of Colorado Medical Center, Denver (1956); Roy Prangley, St. Luke's Hospital, Denver (1956); Msgr. John R. Mulroy, Catholic Charities, 1665 Grant, Denver (1956).

COMMITTEES FOR 1954

Auditing: Paul A. Tadlock, Chairman, University of Colorado Medical Center, Denver; C. E. Buscher, St. Francis Hospital, Colorado Springs; Kenneth Rindflesh, Denver General Hospital, Denver.

Legislative: Louis Liswood, Chairman, National Jewish Hospital, Denver; Hubert Hughes, General Rose Memorial Hospital, Denver; Monsignor John Mulroy, Catholic Charities, Denver; DeMoss Taliaferro, Children's Hospital, Denver; Henry H. Hill, Weld County Hospital, Greeley; Roy Anderson, Presbyterian Hospital, Denver.

Membership: Daniel Ryan, Chairman, St. Joseph's Hospital, Denver; David G. Hutchison, Boulder County Hospital, Boulder; M. A. Moritz, Denver General Hospital, Denver.

Nominating: Louis Liswood, Chairman, National Jewish Hospital, Denver; Henry H. Hill, Weld County Hospital, Greeley; Monsignor John Mulroy, Catholic Charities, Denver.

Nursing: Roy Anderson, Chairman, Presbyterian Hospital, Denver; Dorothy E. Fisher, University of Colorado Medical Center, Denver; Sister Ascella, St. Joseph's Hospital, Denver; Henry H. Hill, Weld County Hospital, Greeley; W. J. Dye, Mennonite Hospital and Sanitarium, La Junta.

SPECIAL COMMITTEES

Rates and Charges: DeMoss Taliaferro, Chairman, Children's Hospital, Denver; Monsignor John Mulroy, Catholic Charities, Denver; Roy Prangley, St. Luke's Hospital, Denver; Henry H. Hill, Weld County Hospital, Greeley; Daniel Ryan, St. Joseph's Hospital, Denver; Elton A. Reese, Alamosa Community Hospital, Alamosa; Roy R. Anderson, Presbyterian Hospital, Denver; Hubert Hughes, General Rose Memorial Hospital, Denver; C. F. Fielden, Jr., Memorial Hospital, Colorado Springs.

Resolutions: James Taylor, Chairman, General Rose Memorial Hospital, Denver; James Henderson, Presbyterian Hospital, Denver.

Public Relations: Charles K. LeVine, Chairman, Beth Israel Hospital, Denver; Harley E. Rice, Porter Sanitarium and Hospital, Denver; C. F. Fielden, Jr., Memorial Hospital, Colorado Springs.

℞

Neo-Synephrine®

hydrochloride

Running noses, sneezing, watery eyes, clogged-up nasal passages quickly yield to administration of Neo-Synephrine hydrochloride — a nasal decongestant of proved clinical value. Ciliary activity is nearly untouched, sting and congestive rebound are practically absent, and effectiveness is undiminished on repeated use throughout the cold season.

Neo-Synephrine HCl

- 0.25% Solution
- 0.25% Spray (unbreakable plastic squeeze bottle)
- 0.25% Solution (Aromatic)
- 0.5% Solution
- 1% Solution
- 0.25% Emulsion
- 0.5% Jelly

Winthrop-Stearns INC.
New York 18, N. Y. • Windsor, Ont.

Neo-Synephrine, trademark reg. U.S. Pat. Off.,
brand of phenylephrine

Meat...

and Adequate Protein Nutrition of the Diabetic Patient

Although formerly it was considered desirable in diabetes mellitus to hold protein intake only slightly above minimal requirements in order to minimize metabolic activity, present day treatment recognizes distinct benefits resulting from liberal protein alimentation.[1] Generous allowances of protein heighten the patient's sense of well-being, improve vigor, and augment the organism's inherent protective forces.

For the adult diabetic, desirable daily allowances of protein range from 1 to 1.5 grams per kilogram of body weight.[1] To assure adequate amounts of protein for growth and maintenance in diabetic children, allowances should range from 2 to 3 grams per kilogram. Following acute episodes during periods of inadequate insulin treatment, the concomitant negative nitrogen balance calls for high protein feeding until lost nitrogen is restored.[2] Though caloric intake is restricted for correction of overweight, protein allowances remain unchanged.

Meat ranks high among the foods qualified to provide the desired amounts of protein in diabetic diets. In fact, meat—because its rich store of protein is of highest biologic value—may well contribute a large share of the diabetic's daily protein requirement.[3]

In addition, meat also provides important amounts of essential B vitamins and minerals. Its appetite appeal goes far in enabling the diabetic patient to stay on his prescribed diet.

---

1. McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 287-299.

2. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. Prepared with Collaboration of the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Publication 234, 1952, p. 56.

3. Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Company, 1951, p. 634.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

tested

broad-spectrum therapy

Terramycin®

BRAND OF OXYTETRACYCLINE

established

an agent of choice

in the treatment of a wide range of infections due to gram-positive and gram-negative bacteria, spirochetes, rickettsiae, certain large viruses and protozoa.

clinical advantages known

rapid absorption — Within an hour after oral administration in fasting or non-fasting state, effective serum concentrations of Terramycin may be attained.[1] It is widely distributed in body fluids, organs and tissues and diffuses readily through the placental membrane.[2,3]

wide distribution

prompt response — Immediate evidence of Terramycin's efficacy is often obtained by the rapid return of temperature to normal.[4] Widely used among patients of all ages, this tested broad-spectrum antibiotic is well tolerated.[5,6]

excellent toleration

1. Sayer, R. J., et al.: Am. J. M. Sc. *221*:256 (Mar.) 1951.
2. Welch, H.: Ann. New York Acad. Sc. *53*:253 (Sept.) 1950.
3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. *74*:261 (June) 1950.
4. Wolman, B., et al.: Brit. M. J. *1*:419 (Feb. 23) 1952.
5. Potterfield, T. G., et al.: J. Philadelphia Gen. Hosp. *2*:6 (Jan.) 1951.
6. King, E. Q., et al.: J. A. M. A. *143*:1 (May 6) 1950.

Pfizer

Available in convenient oral, parenteral and ophthalmic preparations.

PFIZER LABORATORIES, *Brooklyn 6, N. Y.*
Division, Chas. Pfizer & Co., Inc.

All* Tet

*Afebrile → In Hours

". . . reports on its use in patients with pneumococcal pneumonia, surgical infections, or urinary tract infections indicate that the oral administration of tetracycline is followed by rapid clinical response. Symptoms, including fever, largely cleared up within 24 to 48 hours."[1]

1. English, A. R.; P'an, S. Y.; McBride, T. J.; Gardocki, J. F.; Van Haisema, G., and Wright, W. A.: Antibiotics Annual (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.
2. Finland, M.: Brit. M. J. 2:4846 (Nov. 21) 1953.

BASIC chemically

The structure of this *newest* antibiotic represents a nucleus of modern broad-spectrum antibiotic activity.

BASIC clinically

This *newest* broad-spectrum antibiotic has a wide range of action against respiratory, gastrointestinal, soft-tissue, urinary and mixed bacterial infections due to pneumococci, streptococci, staphylococci and other gram-positive and gram-negative organisms.

"Data thus far available would indicate that the use of tetracycline is accompanied by a significantly lower incidence of gastrointestinal symptoms . . ."[2]

This *newest* broad-spectrum antibiotic may often be used with good success in patients in whom resistance or sensitivity to other forms of antibiotic therapy has developed.

tracyn

brand of TETRACYCLINE hydrochloride

BASIC among broad-spectrum antibiotics

supplied:

TETRACYN TABLETS (sugar coated)
250 mg., 100 mg., 50 mg.

J. B. ROERIG AND COMPANY, Chicago 11, Illinois

Rocky Mountain Medical Journal

MARCH, 1954

Colorado - Montana - New Mexico
Utah - Wyoming

Facts—Versus Mr. Connell

THE more we read about the obvious confusion of Mr. Arthur J. Connell, national commander of the American Legion, in his persistent charges that the Colorado "Code of Cooperation" between the press, radio and TV and the medical profession and hospitals is a "contract" designed to suppress news, the more we are convinced as to his objective.

It is our opinion that Mr. Connell is not really endeavoring to pass professional judgment on the Code. He admits that he is neither a physician nor a journalist. We think he should also admit a corollary fact, namely, that he knows very little about either of these professions and knows next to nothing about the democratic plan which brought the Code into being and has kept it functioning for increasing public good for these last six years.

What he really wants to do is to embarrass the American Medical Association, and, if possible, to embarrass the Colorado State Medical Society, the other Rocky Mountain medical associations, and other medical societies over the country which have followed Colorado's lead in making medical news and medical opinion more available to public information media than was the case before World War II.

He wants to embarrass American medicine because the A.M.A. and most if not all of its constituents differ sharply with leaders of the American Legion on the political issue of whether this country should continue to give "free" federally-supported medical and hospital care to veterans for non-service connected ills. Someone gave him a mighty bum steer, and he seems to be persuaded that in Denver there has long been a sinister plot, so cleverly executed that the medical profession has been able to keep the "truth" about the veterans' hospitalization controversy out of the press and has been able to substitute its own supposedly untruthful arguments.

Mr. Connell, whose experiences and official positions should have taught him the facts of life by this time, has grabbed what he thought was the ball and has run with it on this matter of a code of cooperation between medicine and public information media. He has repeatedly charged, ad nauseam, that the code is a "contract," and that it has the practical effect of suppressing presentation to the public of the facts about non-service-connected disabilities and the attitude of the VA and the veterans' association toward them. Instead of defending his and the Legion's stand on its merits, he seeks to befog the issue by charging some supposed conspiracy between the doctors and the media.

This is actually a form of what elsewhere has been named mccarthyism. It is the smear technique. Mr. Connell should be above such things. We feel sorry for him if he is so short of live ammunition that he must fire loud blanks.

One great truth is that Mr. Connell and most Legion leaders (though certain recent polls indicate the Legion membership is divided about 50-50) are frightened by the forthright stand of the A.M.A. and other organizations on the status of the Veterans Ad-

ministration hospitalization issue. The Legion, its leaders, and Mr. Connell personally, have a perfect right to their beliefs and have a perfect right to express them. So does American Medicine. But both sides to what is admittedly a great national issue—that will be debated for months or years to come and will eventually be decided by the Congress—should stick to facts and to arguments reasonably based upon the facts. The Legion, including Mr. Connell, should stay away from unnecessary personalities, and should know by now that untruthful smear tactics do not sit well with Americans as a whole.

He charged, for instance, that Denver newspapers declined to give the Legion space on the V.A. issue. But the Rocky Mountain News gave him nearly four columns of space to present his story on February 12. Instead of informing the public about the controversial political issue, he used most of the space to attack the Code, the press, and the medical profession.

Mr. Connell is especially miffed because the Denver Post happens to agree editorially with the medical profession that federal care for veterans whose ills have no connection with their former military service is wrong. He thinks this proves that the Post and the doctors "conspire" to keep the truth out of the paper. The fact is that we do have a free press in America, and the Post is one of the papers which has been most outspoken concerning its own freedom. It is an aggressive and occasionally sensational newspaper, and, like the rest of us, it occasionally makes mistakes. That it happens to agree with the A.M.A. and with this Journal on the veterans' care issue is, for us, a happy coincidence. The Post and the medical profession have not always agreed; far from it. And, a month from now, the Post may disagree thoroughly and violently with the A.M.A. or with any medical society in the Rocky Mountain region. If it does, it will undoubtedly say so in unmistakable language on its editorial pages. That is its right. In fact, that is its duty as a newspaper in free-press-America. Neither the Legion nor the A.M.A. nor anyone else outside its editorial department makes its editorial policies, or should try to do so.

For Mr. Connell, for those Legion officials who may agree with him, and for any physicians in the Rocky Mountain region who may have been unduly disturbed by his vitriolic attacks against medicine in Washington and in Colorado, let us summarize some facts that are really facts:

1. The Code of Cooperation, originally a 1947 brain-child of a few Denver doctors and newspapermen, was completed in April, 1948, after a long series of informal, nonsecret conferences of a sincerely cooperative nature including representatives of the medical profession, the hospitals, the Colorado Press Association, the Denver newspapers, and the radio stations of Colorado.

2. The Code of Cooperation is a set of principles, which all those concerned agree to abide by so far as is possible, in order to facilitate the obtaining and publishing or broadcasting of accurate health and medical news.

3. The Code of Cooperation is not a contract. It does not now nor has it ever provided for contractual relationships. It is not a signed document on behalf of any of the interested organizations or agencies.

4. It has nothing to do with suppressing news in any way, shape, or form; any time, for any reason.

5. It gives the medical profession no special privilege, no immunity from public criticism.

6. It does not violate any law, nor does it violate the Principles of Ethics of the American Medical Association or the ethical principles of any publishing or broadcasting medium or organization. Its only effect on anyone's principles of ethics is to explain to those interested how physicians and hospitals may follow the published medical ethics and at the same time cooperate with press and radio better than they formerly did.

For readers who wish to go deeper into the matter, your Editors are republishing, beginning on Page 231 of this issue, the complete Code with its recently added television supplement, together with a more de-

tailed history of how it was developed. We in the Rocky Mountain region can be proud of it. It originated here. It has been copied, almost verbatim, by similar physician-hospital-press-radio groups in almost half of the states of the nation and by the National Association of Science Writers, a journalistic organization which itself is highly jealous of its freedom.

Still, Mr. Connell, who infers that we do not have a free press, says that "every lawyer across the country I have shown it to says it is a 'contract'." We conclude that his legal advice is just as bad as his public relations advice.

Midwinter Clinics Growing

COLORADO'S annual Midwinter Postgraduate Clinics last month in Denver recorded 982 registrations, almost a new record, and had a more Rocky Mountain flavor than such meetings have usually enjoyed. Attendance from states other than Colorado was larger than usual, presidents of the other Rocky Mountain states shared by Colorado's invitation in presiding over individual sessions, and for the second year in a row guest speakers included men from Rocky Mountain states as well as from farther afield. The committee in charge, the guest clinicians, and all concerned with preparation and conduct of the meeting deserve congratulations.

At a concurrently held meeting of your Journal's Editorial Board it was the consensus that the more these mountain states of ours can knit themselves together both in scientific medicine and in medical sociology the better for the progress of medicine, public health, and all of medicine's interests in this whole area.

We even heard suggestions that some one of these days the Colorado Medical Society might be willing to give this midwinter meeting a new title better designed to cement our intermountain relations, and that it might well become a four- instead of a three-day meeting. We would welcome comment from our readers.

The Question of Fees

MANY months ago these columns presented an editorial entitled "To All My Patients" and went on to describe and recommend the plaque carrying the A.M.A. seal and available to physicians at a below-cost charge of one dollar. Up until the middle of 1953, only about fifteen thousand of these were being displayed over the nation in our offices. In the sincere belief that there should be nearer one hundred and fifteen thousand, another reminder is hereby placed before you.

Harmonious doctor-patient relationship sometimes ends because of financial discord. The fault is not always ours, however, for probably not over one patient in four asks in advance what his bill will probably be. Furthermore, over half of us are reluctant to introduce the question for fear of appearing mercenary. We are accused of being poor business men. There is ample evidence which attests this widespread belief, but possibly it should be termed financial immaturity. To be fair, let us say that it also applies to many patients—and the combination is ripe for misunderstanding when two financially immature individuals make a deal without clarifying their respective problems. Most patients are as eager to be fair and reasonable as we are. They simply want an approximate perception of the economic responsibilities. They realize there can't be price tags on life and health, that professional fees in general vary with living standards and location—but they don't want to be penalized when thrift and hard work have won for them a superior economic status. It is not their problem if we choose to do a lot of charity work, and most of them are not impressed by our long education and the gruelling grind along the upward path. Chances are that other people also worked, toiled, and sweat to arrive.

There is no better way to repair our public relations and maintain good will of our patrons than to practice the Golden Rule, to revise our fees downward when warranted, but not to raise them above standard to patients whose apparent affluence might seem to justify it. In all instances, advance discussion should be encouraged.

The American Dollar's Best Buy

UNITED STATES Department of Commerce statistics for 1952 show that medical care items showed less increase over 1951 than did pleasure items. Consumer expenditures for all goods and services rose from 208 to 218 billion dollars. The medical care portion increased from 9 to 9.6 billions or from 4.3 to 4.4 per cent of the total. The physician's share of the medical care dollar decreased from 28.1 to 27.8 cents, while the hospital's share rose from 24 to 24.8 cents. Expenditures for tobacco and alcoholic beverages amounted to 14.1 billion dollars in 1952, whereas all health care—drugs, hospital care, physicians' services, and every other health care—added up to 9.6 billions. Recreation took 11.7 billion dollars in that year. Thus, the pleasure items increased more in 1952 over 1951 than did the medical care items.

So there you are, just in case you didn't already have a headache—or perhaps you need a new theme for nightmares!

Lung Cancer Increases

EARLY in 1952, the J.A.M.A. presented a long scientific article based upon a statistical study of incidence and mortality rate of cancer of the oral cavity, respiratory passages, and lungs during the preceding decade. Special emphasis was laid upon the apparent causal relationship of tobacco and its combustion products. For example, cancer of the lung is on the increase in both sexes and occurs twenty or more times more frequently in smokers than in non-smokers.

A recent article in the New England Journal of Medicine by Wynder and Cornfield quotes figures from a survey of exposure to tobacco, and other possible respiratory irritants among sixty-three physicians dying of lung cancer and 133 who died of other cancer. Estimated mortality from lung cancer is 10 per 100,000 non-smoking physicians and 133 per 100,000 who smoke thirty-five or more cigarettes per day. Theoretically, members of our profession are not exposed to industrial irritants as much as the general populace, and they have greater access to diagnostic facilities.

We must admit the controversial nature of this subject. Speakers took opposing views before the American Cancer Society in New York during November. Cancer of the lung in several other countries does not appear to bear the same relationship to tobacco consumption as in America. No one has isolated a specific carcinogenic chemical from tobacco, and some workers are more suspicious of contamination by city air from automobile exhausts, factories, and home heating fuels. More lung cancers occur in cities than in rural areas.

Obviously, more research must be performed. A tumor which kills 21,000 Americans annually and is increasing more rapidly than any other is certainly a leading challenge to our profession and all of the agencies concerned with public health.

Don't Forget The Teeth

PHYSICIANS and dentists sat together recently at a meeting, discussing problems common to both professions. One of the dentists passed a note to the chairman asking the question, "Why have so many patients who come to a dentist for a complete mouth examination seen five to seven M.D.'s before one finally suggests, 'Why don't you have your teeth checked?' " "That is," he said parenthetically and not without malice toward some, "when a tonsillectomy or an hysterectomy won't help."

The dentist had a point, and a good one. Enthusiasm for indiscriminate removal of tonsils and teeth has passed; most physicians recognize and respect the evil of pelvic operations supposed to relieve neuroses and psychosomatic troubles. But sometimes they simply forget that dental sepsis may be the source of many things from vertigo to carbuncles.

Many months ago these columns decried physical examinations without examination of both ends of the alimentary canal with head mirror and gloved finger. While you're at it, how are the teeth?

Retroperitoneal Radiography With Oxygen Injection

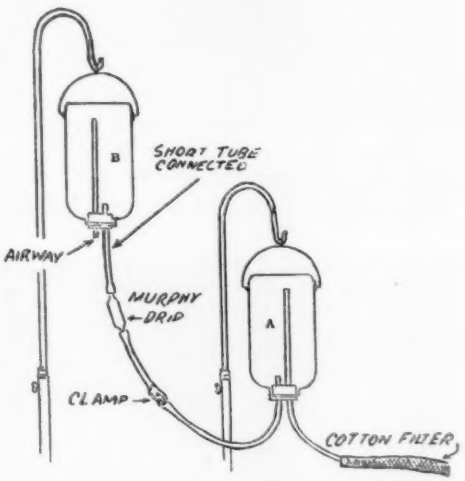
SAM DOWNING, M.D.,
TOM KENNEDY, M.D., and
J. PHILIP CLARKE, M.D.
Denver

PHYSICIANS have utilized the excellent contrast medium of gases to outline, radiographically, structures of the body. For example, air contrast enemas and ventriculography are commonly used diagnostic aids. Adequate x-ray visualization of retroperitoneal structures has long been a problem. The first known reference to the value of gas for outlining such structures was that of Bariani[1], who many years ago noticed that in doing therapeutic pneumoperitoneum, accidental diffusion of gas into the retroperitoneal space occasionally occurred and "outlined the kidneys in a remarkable manner." In 1921, Carelli[2] outlined the kidney and adrenal by injection of carbon dioxide into the perirenal capsule. Cahill[3] reported favorably on this method, using air for the contrast medium. This procedure of injecting gas into a relatively vascular area was not without danger, and because of occasional gas embolism, the method did not gain wide acceptance. It was not until 1950, when Ruiz Rivas[4] described his method of producing retroperitoneal emphysema through a single puncture into the presacral areolar tissues, that a safe and satisfactory method of retroperitoneal structure visualization developed.

The success of the method described by Rivas is dependent upon the anatomical continuity of the areolar tissues of the body, so that gas introduced in one area may be made to diffuse throughout the body. In this way, kidneys, adrenals, retroperitoneal tumors, liver and spleen, and other structures can be well visualized by the contrast medium gas. Some authors have noted visualization of the uterus, tubes, ovaries and bladder. We believe, also, that since the gas passes through the foramina in the diaphragm, that mediastinal tumors, including substernal thyroids, might be outlined.

Technic

The technic we use to produce pneumoretroperitoneum is essentially that used by Steinbach, Lyon, Miller and Smith[5] who described the procedure under the term "extra-peritoneal pneumography."



DIRECTIONS FOR USING OXYGEN DISPLACEMENT APPARATUS

1. Bottle A is filled with sterile water.
2. All connections are secured with adhesive tape to stand moderate pressures.
3. Oxygen is passed into bottle A from Oxygen tank, forcing water into bottle B.
4. Tubing below bottle B is clamped to prevent water from returning to bottle A.
5. Oxygen tank is disconnected and tubing from bottle A is connected with sterile tubing to be attached to needle.
6. Clamp below bottle B is released allowing water to flow back into bottle A and displacing Oxygen into tube leading to needle.

Fig. 1. Oxygen displacement apparatus.

The patient is prepared as for intravenous pyelography, and a sedative is given an hour before the examination. With the patient on his left side, knees drawn up, and with the head of the table elevated about ten

degrees, the anococcygeal area is prepared and draped. A midline wheal is made with novocaine half way between the anus and the tip of the coccyx, and a spinal needle (18 to 20 gauge) is inserted through the wheal and directed toward the tip of the coccyx. The index finger of the free hand is inserted into the rectum to guide the needle tip ventral to the coccyx, through the anococcygeal ligament into the retrorectal space. After aspiration of the needle for blood, and the injection of a small amount of novocaine or air to determine the presence of a free flow, the oxygen injection set is connected to the needle. This set may be a standard pneumothorax machine or the two bottle oxygen displacement apparatus which has been used for many years to induce pneumothorax. In the adult, we inject 500 cc. of oxygen, then turn the patient to the opposite side and inject another 500 cc. Oxygen is allowed to flow at a pressure of 15 to 30 centimeters of water at a rate of about 100 cc. per minute. When the needle is removed, the patient is placed in the prone position with the head of the table raised 15 degrees.

Usually, the best outline of retroperitoneal structures is obtained two to four hours after the oxygen injection. Progress of gas diffusion is checked by an occasional roentgenogram, and if the viscera of one side are not being properly outlined, the patient is positioned so that side is superior —encouraging gas to diffuse into the area desired. When adequate diffusion of the oxygen has taken place, intravenous or retrograde pyelography, and/or aortography may be carried out if desired. The gas is slowly absorbed, traces being present seventy-two hours later.

We would like to stress several aspects of the procedure outlined above. First and foremost, is the safety factor—chance for gas embolism is extremely remote, since the injection is made into a relatively avascular area. Second, the procedure is practically painless. Occasional transient groin or back pain is the only discomfort we have noted. Third, the simplicity of the method should encourage any physician of average dexterity to perform it. Finally, the degree of contrast on the abdominal roentgenograms is usually adequate to fulfill the diagnostic requirements of the case.

We wish to present six cases in our series, to demonstrate the value of this method.

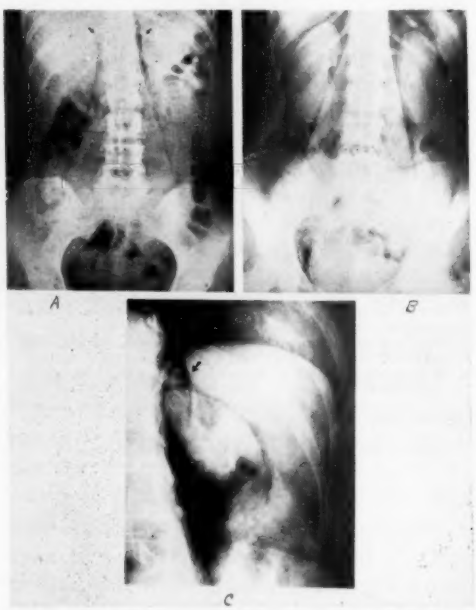


Fig. 2. A. Shows normal size adrenal glands. B. Shows normal adrenal-kidney areas. C. Shows normal size adrenal glands.

CASE 1

J. L., 36-year-old white male, was admitted to Presbyterian Hospital in February, 1953, because of hypertension. Benzodioxane and regitine tests were not diagnostic, although the regitine test was suggestive of an adrenalin producing tumor. Presacral oxygen injection visualized the renal and suprarenal areas, showing no evidence of adrenal tumor. This patient later had a bilateral lumbo-dorsal sympathectomy.

CASE 2

F. B., female, aged 58, entered Presbyterian Hospital in July, 1953, because of painless hematuria five weeks before admission. Retrograde pyelograms had suggested the possibility of neoplasm in the lower pole of the right kidney, but were not conclusively diagnostic. X-rays following presacral oxygen injection demonstrated a bulbous expansion of the lower pole of the right kidney, with concurrent intravenous pyelograms showing a normal appearing pelvis and calyces. At operation a hypernephroma of the lower pole of the right kidney was found.

CASE 3

T. B., white male, aged 35, entered Presbyterian Hospital in March, 1953, with pain in the

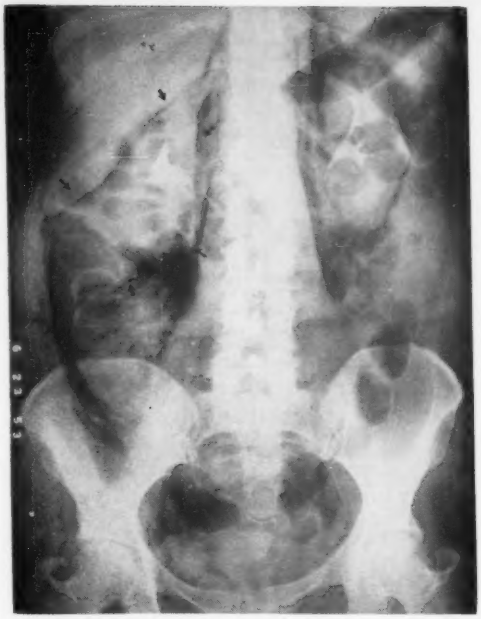


Fig. 3. (Case No. 2). Hypernephroma—lower pole right kidney—bulbous expansion well outlined by retroperitoneal gas.

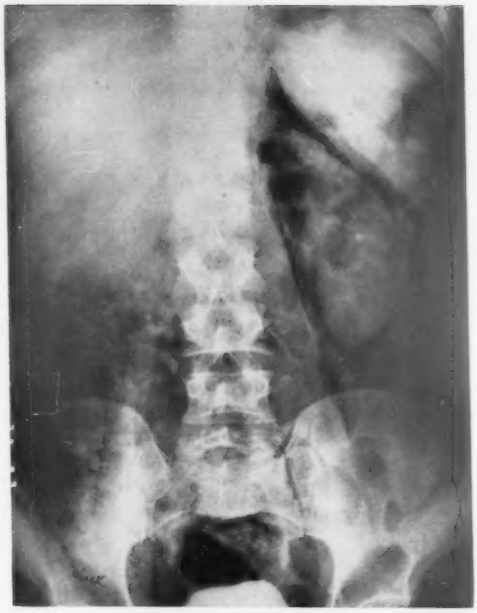


Fig. 4 (Case No. 3). Large adrenal gland carcinoma prevents gas from entering retroperitoneal area about right kidney. Well vizualized left kidney and psoas muscle.

right upper abdomen, flank, and lumbar area of about five months' duration. Three weeks prior to admission, pain became severe enough for him to seek aid, at which time the physician could feel a mass in the right upper abdomen, not definitely distinguishable from an enlarged liver. Roentgenograms following presacral oxygen injection showed a large mass displacing the right kidney downward and laterally. At operation, a carcinoma of the right adrenal gland was found with massive hemorrhage into the tumor.

CASE 4

K. P., four-year-old male, entered Children's Hospital in July, 1953, because of painless hematuria. Intragluteal pyelography showed no excretion on the left side where a mass was suspected. At cystoscopy, the left ureter could not be entered. Presacral oxygen (150 cc.) injection helped outline a large mass occupying the position of the left kidney. At operation a large hydronephrotic kidney and hydroureter were found.

CASE 5

B. L., 35-year-old white female, entered Presbyterian Hospital in April, 1953, because of amenorrhea of six months' duration. In 1948 she had developed amenorrhea, hematuria, deepening of the voice, and a generalized masculine type of hirsutism. A carcinoma of the left adrenal gland was removed at that time, after which the patient had a normal pregnancy and two spontaneous abortions. Since the last abortion in 1952, she had not menstruated. Her voice became deeper and hirsutism more prominent. Presacral

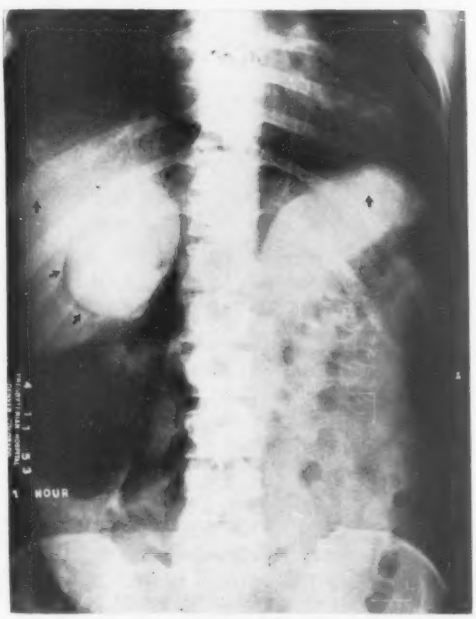


Fig. 5. (Case No. 5). Large mass, right adrenal area plus basilar pulmonary metastasis.

oxygen injection outlined a mass in the region of the right adrenal, representing either adrenal neoplasm or metastases in this area. Because of evidence of pulmonary metastases, this patient did not have surgery. Her 24-hour urinary 17-ketosteroid level was 1500 milligrams—one hundred times the normal.

CASE 6

B. J., 52-year-old white female, entered Presbyterian Hospital in September, 1953, with generalized abdominal pain, fatigue, and gradual weight loss of forty pounds. Abdomen was tender and tense but an indistinct mass could be palpated on her left side. A presacral oxygen study demonstrated an atypically enlarged spleen and also an enlarged liver, with both kidneys being depressed inferiorly.

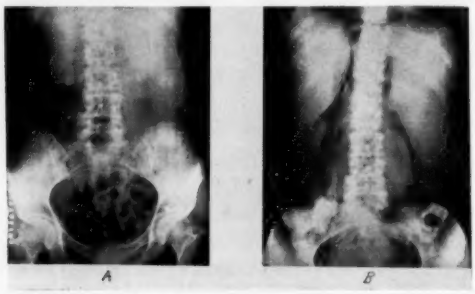


Fig. 6. (Case No. 6). A. Flat plate of abdomen—not diagnostic. B. Same patient after retroperitoneal oxygen injection—shows large liver and spleen displacing kidneys inferiorly.

Discussion and Summary

The value of any method which assists in safely outlining retroperitoneal structures cannot be over-emphasized. Conditions where the procedure is of value are many and varied. We have presented cases showing this. Even the negative value of the procedure in disproving adrenal gland tumors is of considerable worth by itself and may save many needless surgical explorations. One must bear in mind, of course, that gas cannot be made to enter a space that has been closed by inflammatory reaction, pressure from an enlarged organ, hemorrhage, or postoperative adhesions. The authors submit that Dr. Rivas has given us a valuable diagnostic tool, one which may be used by physicians in many specialties with benefit to their patients.

REFERENCES

[1]Bariani, cited by L. de Gennes, J. P. May et G. Simon: Le Retropneumoperitoine, La Presse Medicale., 58:351-352, April, 1950.

[2]Carelli, H. H., et Sordelli, E.: Induced Emphysema for Exploring Kidney. Rev. Assoc. Med. Argent., 34:424, 1921.

[3]Cahill, G. F.: Air Injections to Demonstrate the Adrenals by X-Rays. J. Urol., 34:238, 1935.

[4]Rivas, M. Ruiz: Generalized Subserous Emphysema Through a Single Puncture. Am. Jour. Roent. et Radium Therapy, 64:723-734, Nov., 1950.

[5]Steinbach, Howard L.; Lyons, Richard P.; Miller, Earl R.; et Smith, Donald R.: Extraperitoneal Pneumography: A Preliminary Report. California Med. 75:202-206, Sept., 1951.

The A.D.A. Forecast

Physicians throughout the country have found in the "A.D.A. Forecast," published by the American Diabetes Association, a valuable supplement to the teaching which the physician gives his patients in the many problems which arise in the proper management of diabetes. In addition, an improved morale in many patients has come about by virtue of such features as "Dave's Diary" and other cheery, inspirational articles.

The "A.D.A. Forecast" is an authoritative publication, edited by Frederick W. Williams, M.D., one of the founders of the American Diabetes Association, and has a distinguished medical Editorial Advisory Board which includes Charles H. Best, M.D., a co-discoverer of insulin.

Typical articles in recent issues of the Forecast include: "The Care and Handling of Insulin Syringes," "Marriage and the Diabetic," "The Gentle Art of Job Hunting for Diabetics," "Life Insurance for Diabetics," "Income Tax Deductions for Diabetics," "The Child With Diabetes," "Summer Camps for Diabetics," "Help Others to Learn What You Have Learned," and "Restaurants I Have Known, or How to Live with Chefs and Like It!"

Subscriptions are available to all at $2.00 a year, $3.50 for two years or $4.75 for three years. The Forecast is published bimonthly by the American Diabetes Association, 11 West 42nd Street, New York 36, N. Y.

Sample copies and subscription forms are available without cost to any physician for use with his patients.

Bicipital Tenosynovitis

PAUL R. YEDINAK, M.D.
Rock Springs, Wyoming
and
BOYD G. HOLBROOK, M.D.
Salt Lake City, Utah

PAINFUL shoulder and the "frozen shoulder syndrome" appears frequently and results in serious disability. Disease of the tendon of the long head of the biceps muscle is often responsible. In the past several years the pathology and treatment have been clarified. The necessity now is for the popularization of these concepts of diagnosis and treatment. Every doctor can recall a patient with a painful, stiff shoulder he has managed in one way or another. In the early stage the patient presents himself with the complaint of a chronically painful shoulder which hurts at the extremes of abduction and rotation. The pain is referred chiefly to the anterior region of the shoulder, anterior surface of the arm, or even to the flexor surface of the forearm. The patient is more often a woman than a man, in the age range of 40 to 60 although 25 or 70 is not rare, and the right shoulder is involved more often than the left. Frequently concomitant cardiovascular, pulmonary, or metabolic disease is present. The patient is as frequently a clerical worker as a laborer, a secretary as a housewife. About one in three can relate the painful shoulder to some traumatic incident—a fall on the hand or elbow, a sudden pain with heavy lifting, or an old fracture, sprain, or contusion about the shoulder. The others state that the pain has appeared with no apparent cause. If the patient is treated with reassurance and some form of heat and rest, a number of the shoulders will undergo improvement. Some, however, will increase in severity and become disabling.

The patient seen later in the course of this disease not only complains about pain in the shoulder, but of stiffness and limitation of motion as well. The shoulder which was first painful only at the extremes of motion becomes painful with all or any motion. The range of shoulder motion at the scapulo-humeral joint may progressively diminish until the arm is held protectively and uselessly at the side. The pain becomes constant and interferes with rest and sleep and the patient is unable to lie on the affected side. Occasionally the distress spreads from the shoulder into the neck. With prolonged immobility and lack of use the shoulder girdle muscles become atrophic and the prominence of the shoulder is flattened.

The findings elicited on examination vary with the stage of the disease. Early, the arm is moved about in the central arc of motion with ease, but the patient winces with pain on external rotation or abduction. Later, the scapulo-humeral joint may be held rigidly fixed and the only motion demonstrable by the arm can be completely stopped by preventing movement of the scapula. About two or three inches below the shoulder joint, on the anterior aspect of the arm, marked tenderness is elicited. The patient usually seems surprised at the location of tenderness. If the patient is asked to actively flex the elbow and supinate the forearm to bring the tendon of the long head of the biceps muscle under tension, pushing the tendon gently aside and allowing it to spring back to its normal position will invariably produce a protest of pain. This is a pathognomonic sign. The tendon is unquestionably tender.

It has been written by several authorities that the disease always undergoes remission, with disappearance of pain and gradual and complete restoration of motion. The course may run for a few months or a few years. De Palma objects to this statement and records three patients with symptoms of five, six, and eight years' duration with no signs of remission. Nonetheless, the usual frozen shoulder, if watched long and patiently enough by the doctor and tolerated by the patient, will gradually lose much of the pain

*From the Department of Orthopedic Surgery, University of Utah Medical School, and the Veterans' Administration Hospital, Salt Lake City, Utah. The opinions expressed herein are those of the authors and do not necessarily represent the views of the Veterans' Administration.

and increase its range of motion. Even these cases, however, have a residual weakness and loss of some external rotation and abduction. Such is the clinical picture of the patient with the "frozen shoulder syndrome."

The pathologic clarification of the syndrome has involved years of careful work by several investigators. Their work is referred to in most discussions of the subject. They have all seen the same pathology and recorded it in nearly identical language. Not all, however, have put the same interpretation on the findings. Invariably there is evidence of inflammation of the tendon of the long head of the biceps brachii muscle and its sheath. The tendon may be bound to the sheath with multiple fine fibrous adhesions and the sheath injected and somewhat edematous. In more advanced disease the tendon is frayed and fibrillated, with obvious partial disruption, and the tendon-sheath is thickened and fibrous. Granulations may be demonstrable throughout the region of the bicipital groove. In the most prolonged cases the tendon is bound to the floor of the groove by tough adhesive bands. It may have disrupted completely and its distal portion reattached to the floor of the groove, the proximal stub hanging free in the joint or having completely disappeared. This is frequently the situation in the cases that have undergone resolution with remission of symptoms.

Some abnormality of the intertubercular groove may be present to explain the tendon lesion. A bony roughening or excrescence may be present in the floor, the groove may be roughened due to previous fracture, or may be abnormally shallow, allowing recurrent dislocations of the tendon. X-rays of the shoulder should be obtained but are almost uniformly normal. An axial view may show a bony proliferation on the floor of the intertubercular sulcus. There may be spotty decalficication about the greater tuberosity and down the shaft of the humerus. Anything more spectacular is rarely seen.

Consideration of the local peculiarity of the anatomy gives further clarification of the problem of the long-head tendon. Contrary to the usual thinking, it is not the tendon which moves through the bicipital groove, but the humerus which moves on the fixed tendon with motion of the shoulder joint. From adduction to complete elevation of the arm a given point in the groove moves along the tendon for a distance of at least one and a half inches. It seems logical that adhesions fixing the tendon to the periosteum of the humerus will transmit tension to the surrounding tissues with resulting pain. The biceps sheath is closed only at its lower end. It is really a sac or pouch extruded from the joint lining. It extends down the bicipital sulcus for about two inches, then is reflected upon itself and returns to the joint.

Further anatomic consideration of the shoulder joint as a whole immediately discloses the two large gliding surfaces produced respectively by the deltoid cowl and the deeper hood formed by the musculotendinous cuff. These large surfaces provide opportunity for adhesion and agglutination between gliding surfaces. With the shoulder forced to relative or complete immobility by pain, venous and lymphatic stasis occurs, the local metabolism is altered, and the gliding surfaces become covered with sero-fibrinous exudate and are later glued by the organization of the exudate to fibrous adhesions. This then becomes an additive factor in the disability caused by the bicipital tenosynovitis. Microscopic examination of the tissues of the region shows inflammatory infiltration, increased vascularity and advanced hyperplasia.

Treatment of the frozen shoulder is determined by the stage of the disease. Vigorous non-operative treatment is offered to all cases. If, after suitable passage of time spent in conscientious effort by the patient and the doctor, relief has not occurred, operative theapy is indicated and almost uniformly successful. In the initial phases of the disease, when inflammatory changes have not become irreversible, conservative treatment with sedation for pain, application of heat, local procaine injections and exercises may be successful. By careful palpation the point of maximum tenderness is located and infiltrated with 10 c.c. of 1 per cent procaine. This is repeated at intervals of four to ten days until recovery is

assured or it is felt to be of little or only temporary value. Stellate ganglion block sometimes has a remarkable effect on the pain. Injection of 15 to 20 c.c. of 1 per cent procaine to anesthetize the stellate ganglion and its autonomic neurovascular control of the upper extremity will occasionally produce spectacular relief. This procedure is repeated daily or on alternate days. The period of relief following each injection tends to become longer. This should be accompanied by active progressive exercises gradually increasing the range of joint motion. With the pain controlled, the patient is willing to exercise the joint and gradually increase its range of motion by physiotherapy.

Conservative treatment often fails and operative approach to the pathology is then indicated in the following manner. Under a general anesthetic with the patient in a semisitting position, a standard approach to the anterior shoulder is made. We have used the "S" shaped incision described by Hitchcock and Bechtol and recommended by De Palma. This begins at the acromio-clavicular joint, extends medially to the coracoid process, curves gently lateralward and distally to the biceps tendon, and gradually again medially down the arm about four inches below the shoulder. This skin incision does not tend to form the widespread scar of other approaches. The cephalic vein in the delto-pectoral groove is identified and the full thickness of the deltoid muscle split about one-quarter inch lateral to this landmark. The deltoid is split from the lower end of the incision to its origin on the clavicle. The deltoid cowl is retracted laterally and by internal rotation of the shoulder the subacromial bursa and the musculo-tendinous cuff are inspected.

Calcium in the bursa or in the supraspinatus tendon is removed when encountered. The shoulder is then rotated to its neutral position. The transverse humeral ligament, coracohumeral ligament, and joint-capsule covering the tendon are incised to allow complete visualization of the tendon from near the glenoid tubercle point of origin to its point of disappearance beneath the tendon of the pectoralis major muscle. The origin of the tendon at the glenoid is cut through with scissors and the freed tendon removed from the groove. The incised transverse humeral ligament and joint capsule are repaired with fine interrupted sutures.

What to do with the freed long biceps tendon is subject to mild controversy. It may be reattached to a freshly-made groove in the floor of the bicipital sulcus, attached to the lesser tuberosity, or attached to the tip of the coracoid process and tendon of the combined heads of the coracobrachialis and short biceps muscle. We have preferred the latter. In any case the tendon is removed from the groove and the possibility of further trauma to it obviated. At no time before, during, or after the procedure is the scapulo-humeral joint put through a full range of motion. This serves only to add injury with traumatic tearing of adhesions and an increase in fibrous tissue. Before closure the coraco-acromial ligament is divided near the acromion to allow the head of the humerous to pass freely beneath the coraco-acromial arch. The wound is closed and the arm dressed with either a Velpeau or sling and binder.

In two or three days the arm is put in a conventional sling and the patient is encouraged to begin pendulum exercises. The readiness with which the arm is exercised is surprising. Occasionally, the patient will volunteer that the pain he has suffered for months or years has already disappeared. In the next ten to fourteen days active exercises are graduated to an increasing range of motion. At this time finger-walking, pulley and wheel exercises are added. In six to eight weeks the patient can return to the full range of his usual activities.

Manipulation of the shoulder joint is mentioned only in condemnation. The traumatic tearing of adhesions about a joint weakened by long disuse atrophy can only result in harm. The adhesions become stronger than the ligamentous structures. Tears of the supraspinatus tendon and other portions of the musculo-tendinous cuff have been observed and recorded by several writers.

The following cases demontrate the typical findings and course of bicipital tenosynovitis:

CASE 1

A 55-year-old woman was first seen March 21, 1952, because of severe disability of the right shoulder. She was in an accident October 17, 1951, and suffered a head and chest injury. The pain in the shoulder had a gradual onset following this accident and had become progressively worse. She was treated with diathermy and liniment. There was almost complete loss of scapulo-humeral motion and constant pain, particularly when lying on the shoulder or attempting to move it. This pain was described as being diffuse about the whole shoulder and radiated into the area of the biceps. Point tenderness was present over the bicipital tendon. During the next five weeks she received five injections of 10 c.c. 1 per cent procaine. She was last seen May 12, 1952, at which time she stated that she had a slight occasional ache in the shoulder and had regained a full range of active motion.

CASE 2

A 30-year-old heavy-duty aircraft mechanic appeared on April 10, 1952, with the complaint of a painful right shoulder. In August of 1951 while in Korea he had been lifting a heavy weight and felt a sudden snapping pain in the right shoulder. Following this his right arm and shoulder had been stiff and painful. Examination revealed no limitation of shoulder motion, but the extremes of abduction and external rotation caused pain. Marked tenderness was elicited on palpation of the biceps tendon. This patient was treated as an out-patient with twice-weekly injections of procaine into the area of the biceps tendon. After each injection the patient stated that the shoulder was painfree. A stellate ganglion block also produced several hours of relief, but the patient preferred local injections. After four months of this treatment, the patient felt his shoulder was no better. On August 7, 1952, a transplant of the long head of the biceps tendon to the coracoid was performed. The tendon was injected and edematous, as was the tendon sheath. No abnormalities of the musculo-tendinous cuff were found. Pendulum exercises were begun on the third postoperative day and the patient was discharged on August 20, with complete relief of his pain. Follow-up observation eight weeks later revealed the patient to have a full range of pain-free motion of the shoulder.

CASE 3

A 56-year-old deputy sheriff entered the hospital on April 20, 1952, with the complaint of a painful right shoulder of two months' duration. He also stated that the shoulder was stiff and that he could not comb his hair with the right hand nor put his right hand in his rear pants pocket. Two months previously the patient had fallen from a height on his hip and outstretched right arm. He was not hospitalized and did not lose work. X-rays had shown no evidence of fracture. Two weeks following the injury, he began suffering from pain in the lateral aspect of the right shoulder, extending down the anterior aspect of the arm and onto the flexor surface of the forearm. Examination revealed marked limitation of abduction and rotation. There was some deltoid atrophy. Pressure over the region of the tendon of the long head of the biceps revealed marked tenderness. Stellate ganglion block produced good relief from pain and increased the range of motion of the joint somewhat. Blocks were repeated daily for four days, but the period of pain-relief was never longer than two hours. The patient requested surgery for the shoulder disability. On April 30, 1952, the tendon of the long head of the biceps was transferred to the coracoid process. The tendon and tendon sheath at the time of surgery showed a moderate degree of injection and edema. The patient began pendulum exercises for the shoulder on the second postoperative day and vigorous physiotherapy on the fifth day. He was discharged from the hospital on May 10, at which time he stated that his shoulder was free of pain. He returned on May 31 and stated that he could now put his right hand in his rear pants pocket and comb his hair with his right hand. Abduction was possible to 90 degrees. On October 20, 1952, six months postoperatively, the patient stated he had no pain in the shoulder. Abduction was possible to 135 degrees and the range of rotation had increased to 75 per cent normal.

CASE 4

A 58-year-old alcoholic salesman was admitted to the hospital with an inferior dislocation of the left shoulder associated with a fracture of the greater tuberosity of the left humerus. Under brachial block anesthesia, the shoulder dislocation was reduced and the arm mobilized in a plaster shoulder spica. X-rays showed satisfactory position of the fragments. Three weeks later the cast was removed and pendulum exercises begun. He was discharged from the hospital on September 2, 1951, but on September 27 the patient returned with complaints of persistent pain and limitation of motion of the left shoulder. The pain extended down the anterior surface of the left arm, forearm, and into the entire hand. He complained of a burning sensation and excessive perspiration in the hand. Examination revealed limitation of all movements of the left scapulo-humeral joint, tenderness over the tendon of the long head of the biceps, and a flushed, moist appearance of the right hand. Symptoms were somewhat relieved by a stellate ganglion block. This was repeated on three successive days, and followed by a continuous stellate block for another three days. The patient then complained that the pain had returned with greater severity, and the block was discontinued. On November 7, 1951, the patient was taken to surgery and the tendon of the long head of the biceps was transferred to the coracoid process. The acromion process was also excised to allow abduction of the humeral head heneath the coraco-acromial arch. Forty-eight hours after surgery the patient stated that his shoulder pain had gone, but the burning sensations in the left hand persisted. He was begun on pendulum exercises and later massage, heat, and vigorous physiotherapy. He was discharged three weeks after surgery with some increase in range of motion, absence of shoulder pain, and persistence of the flush and burning in the left hand. This patient returned to the hospital with a melanoma of the choroid of the right eye on August 1, 1952, for which an enucleation was performed. When last seen eleven months following surgery he was able to abduct the shoulder to 115 degrees and there was no shoulder pain. The burning sensation in the hand remained his chief complaint.

CASE 5

A 48-year-old contractor was seen August 5, 1952, complaining of severe pain and continuous aching in the left arm and shoulder. The pain had interfered greatly with sleep. Onset was in 1946 and was diagnosed as sub-deltoid bursitis.

This disappeared with heat and bed-rest. Pain recurred more severely four months later and persisted. He had been hospitalized twice more in 1946 and again in 1949. Each time he was treated with bed-rest, continuous traction to the left arm to increase abduction and external rotation, heat, and physiotherapy. These measures had given temporary relief and increased the range of motion of the joint for a few weeks. The pain and limitation of motion of the shoulder had been progressively severe since the onset in 1946, however. Examination revealed a tired-appearing 48-year-old man who held his left arm protectively at his side. All motion of the scapulo-humeral joint was absent, the patient being unable to move his arm when the scapula was fixed by the examiner. Any passive motion produced pain. Marked deltoid atrophy was obvious. Tenderness of the shoulder was limited to the region of the tendon of the long head of the biceps. A stellate ganglion block gave no relief of pain. On August 11, 1952, a transfer of the long head of the biceps tendon to the coracoid process was performed. The tendon was enlarged to once and a half its normal diameter. It was dull white in color. The sheath was greatly thickened and involved with granulation tissue. Six hours postoperatively the patient volunteered the information that the pain in his shoulder for the previous six years had disappeader. Physiotherapy was begun on the fourth postoperative day and the patient discharged from the hospital on August 26, 1952. At the time of discharge he had about 25 per cent of normal scapulo-humeral motion and stated that he had no pain. This case is presented because of the prompt and striking relief of pain following surgery, even though the patient has been lost to follow-up.

Summary

The pathology of bicipital tenosynovitis and the frequent resultant "frozen-shoulder syndrome" has been described. It is the responsibility of the medical profession to become aware of the entity and its treatment. Inflammation of the tendon of the long head of the biceps brachii muscle and its sheath is the common denominator of the disease. Demonstrable tenderness of the tendon is the pathognomonic sign.

Conservative treatment is frequently successful. Operative treatment is sometimes necessary with gratifying results.

REFERENCES

1. De Palma, A. F.: Loss at Scapulo-humeral Motion (Frozen Shoulder). Ann. of Surgery 135:193-204, 1952.
2. Hitchcock, H. H., and Mechtol, C. O.: Painful Shoulder; Observations on the Role of the Tendon of the Long Head of the Biceps Brachii in Its Causation. Journal Bone & Joint Surgery, 30:263-273, 1948.
3. Lippman, Robert K.: Frozen Shoulder; Periarthritis; Bicipital Tenosynovitis. Arch. Surgery, 47:283-296, 1943.

Intramuscular Chloramphenicol Treatment of Trachoma

J. B. CHASTAIN, M.D.
Brigham City, Utah
and
L. K. NEWLIN, M.D.
Pine Ridge, South Dakota

TRACHOMA is a disease which remains of considerable clinical importance in the western states and mountainous areas of the southeastern states. By examining Indian adults on the reservations, and their children in boarding schools, the authors have found that trachoma is still very prevalent. Treatment of trachoma in this country was radically altered in 1938 when Loe reported the successful use of sulfanilamide in treatment of the disease[1]. More recently the new wide-spectrum antibiotics have been given considerable trial with varying results. Thus far, reports have been confined to the use of these antibiotics either orally or locally, or a combination of the two.

Here in the West many private physicians are called upon to treat Indians, whites who come in contact with Indians, and individuals of mixed blood. Since trachoma is relatively uncommon in most parts of the United States, the disease is usually not considered by physicians in this locality even though incidence of the disease is known to be high among Indians. This failure to think of trachoma results in diagnostic errors which might be avoided if the disease is considered in differential diagnosis of all ocular infections, regardless of race or occupation. Frequently handled objects such as door knobs and currency may be the means by which the disease is occasionally spread to the white population.

•The authors wish to acknowledge the assistance of the Department of Clinical Investigation, Parke Davis and Company, in supplying chloramphenicol parenteral suspension for this investigation. Dr. Morris S. Fleischman, Brigham City, Utah, assisted in the treatment and follow-up of patients. The U. S. Public Health Service has "loaned" Drs. Chastain and Newlin to the Bureau of Indian Affairs.

The object of this paper is to (1) emphasize the importance of considering trachoma as the possible etiology of ocular infections seen in the western states, and (2) evaluate intramuscular chloramphenicol in treatment of active trachoma. Chloramphenicol is compared with sulfadiazine as to effectiveness, length of treatment, and incidence of drug toxicity.

Reasons for investigation of intramuscular chloramphenicol in the treatment of trachoma are as follows: (1) The sulfas and antibiotics commonly used in the treatment of trachoma are at times ineffective or allergenic. (2) A shorter treatment for trachoma is desirable. (3) In many instances, particularly those involving the lower classes, parenteral therapy is more desirable than oral therapy.

Chloramphenicol Parenteral Suspension

An especially prepared suspension of chloramphenicol was used. Crystal size was controlled in order to assure ready suspension, easy administration, and relatively uniform absorption. An inert dispersing agent has been added to the formula to speed up the suspending process. One gram of chloramphenicol is contained in 2.5 c.c. of the suspension[2]. This product has been previously used most effectively in the treatment of H. Influenza meningitis, veneral diseases, and other infections. Intramuscular injection of 1 to 2 grams of chloramphenicol has been found to result in adequate blood levels within a few hours. As much as 4 grams of chloramphenicol have been administered intramuscularly as a single dose without evidence of toxicity[3].

Classification

Classification of trachoma patients was based on the four stages described by MacCallan[4]. Briefly, these are as follows:

Stage 1. Early trachoma. There may be photophobia, lacrimation, pain, blepharospasm, or sensation of foreign body. Symptoms are usually minimal or absent, however. A definite diagnosis is difficult and cannot be made except by the demonstration of the inclusion bodies of Prowazek.

Stage 2. Inflammatory changes are obvious, and trachomatous changes may be so prominent as to make possible a definite clinical diagnosis. This stage lasts until appearance of scar tissue. Papillary hypertrophy and the appearance of heavily injected parallel folds in the cul-de-sac may be seen.

The pannus usually develops toward the end of Stage 2 or in Stage 3. The finding of pannus formation is diagnostic. The patient is seen to have severely injected superficial vessels growing from the limbus into the cornea. The presence or absence of pannus formation may be readily determined by observing the corneal margins with a hand slit lamp. (This useful instrument may be purchased at a cost of less than that of the average ophthalmoscope).

Stage 3. The onset of scarring marks this stage. As a rule the symptoms mentioned under Stage 1 as occasionally occurring are not present until this stage is reached. Striae develop on the tarsal conjunctivae and may gradually develop into a network of fine fibrous strands.

Stage 4. Cured stage. There is no infiltration, conjunctival inflammation or papillary hypertrophy.

Cases Studied and Methods

A total of forty-five adolescent Navajo Indians of both sexes were treated for trachoma at a large off-reservation boarding school operated by the Federal government. These patients ranged in age from 11 to 18 years. Two Sioux Indian children, ages 4 and 12 years, were also treated; these Sioux children lived at home and not in a boarding school. Diagnosis was based on the presence of active pannus, conjunctival injection, clouding of the upper cornea, papillary hypertrophy, and unevenness of the cornea.

Patients with late Stage 2 or Stage 3 trachoma having negative smears for secondary infection are reported in this paper. Patients with trachoma 1 or early trachoma 2 were also treated beneficially but are not reported since trachoma in these early stages can easily be confused with other ocular infections[5]. In order to rule out absolutely the possibility of diagnostic error, only patients with unmistakable pannus formation are reported.

Chloramphenicol in the amount of one gram was injected intramuscularly at daily

intervals. The patients were carefully followed with the slit lamp and their progress noted. No local therapy was used in treating any patient receiving chloramphenicol injections. Complete blood counts and urine analysis were done every third day during treatment.

Those patients on sulfadiazine therapy received one-half grain of the drug per kilogram of body weight orally every twelve hours. Sodium sulfacetamide ophthalmic ointment, 10 per cent, was used locally with each dose of sulfadiazine.

Neither age, sex, nor degree of ocular involvement had any bearing in determining which type treatment was to be given to each individual patient. Patients who received chloramphenicol therapy were chosen at random; the only exceptions were those few patients who were given chloramphenicol after failing to benefit from sulfa.

Results

Twenty-six patients received the combination of sulfadiazine orally and sodium sulfacetamide locally. A good response was obtained in twenty-two patients (84.6 per cent). Of the four patients who failed to benefit from sulfa, one patient was allergic to the drug, another relapsed shortly after receiving three weeks' treatment, and two others showed no improvement with this type medication. Those patients who responded to treatment showed inactivation of the disease in ten to twenty days. Apparently, patients who do not respond to three weeks of sulfadiazine therapy will probably not respond to the drug if it is given for a considerably longer period.

The four patients not benefiting from sulfa therapy were given chloramphenicol injections with excellent results. In addition to these four patients, twenty-one others received chloramphenicol parenteral suspension with resultant inactivation of the disease. A cure was not immediately effected in three of these twenty-one patients even though the initial response was good. Two of these three patients developed ocular symptoms a few weeks after the initial treatment. The third patient had no ocular symptoms four months after treatment but still appeared to have active pannus formation in one eye. All three patients responded to additional chloramphenicol injections. These three patients were among the first treated, and at the time injections were discontinued, each child still had evidence of active pannus formation. Therefore, after the first few weeks of the investigation, it became obvious that treatment should be continued until the pannus appeared moderately gray in color. There was no need to retreat any patients after this basis for treatment became known.

Thus, treatment of trachoma with chloramphenicol parenteral suspension was highly successful. Symptoms improved in twenty-four to forty-eight hours and usually subsided altogether in three or four days. An average of about nine injections appeared to be sufficient to inactivate the disease. It is probably technically incorrect to speak of these patients as being "cured" since scarring persisted in those patients who had scarring at the beginning of treatment. There was no evidence of either local or systemic toxicity.

Comment

Trachoma treatment is almost always difficult to completely evaluate since patients usually return to their old environment after treatment. Should active trachoma develop at a later date, there is usually difficulty in determining whether the findings represent reinfection or relapse. In this series of forty-seven patients, forty-five patients lived in a boarding school with no opportunity to return to their reservation homes six hundred miles away. These students were excellent clincial material since there was little chance of reinfection after treatment. Also, follow-up was simple.

On the other hand, this series included no middle-aged or elderly patients with active trachoma and extremely severe scarring, such as the authors have seen on the Navajo reservation. Such patients always require longer treatment than is necessary for younger individuals. Too, the patients included in this series have been observed for relatively short periods averaging about six months after completion of treatment.

Summary

1. Trachoma should be considered in the

differential diagnosis of all ocular infections occurring in the Rocky Mountain area, regardless of race, age, sex or occupation.

2. A total of twenty-five patients having late Stage 2 or Stage 3 trachoma were successfully treated with daily intramuscular injections of one gram of chloramphenicol. There was no additional local medication of any type. Patients treated with chloramphenicol parenteral suspension were inactivated in an average of nine days. There were no significant blood or urinary changes, also no allergic reactions. There was no evidence of local reaction at site of injection.

3. Twenty-six patients received a combination of sulfadiazine orally and sodium sulfacetamide ophthalmic ointment, 10 per cent, locally. Twenty-two patients (84.6 per cent) responed favorably to sulfa therapy. Two patients who failed to respond to the sulfadiazine-sodium sulfacetamide combination, one patient who relapsed following treatment with sulfa, and one patient who was allergic to the drug all responded to chloramphenicol injections.

4. Patients treated with chloramphenicol injections should be continued on this therapy until the pannus has lost its injection and appears moderately gray in color.

5. The authors feel that many more trachoma patients must be treated and observed over longer periods of time before a complete evaluation of intramuscular chloramphenicol can be made.

REFERENCES

[1]Loe, F.: Sulfanilamide Treatment of Trachoma, Preliminary Report, J.A.M.A., 111:1371, October 8, 1938.

[2]From product description given by Parke, Davis and Company.

[3]Romansky, M. J.; Caldwell, E. R.; and Meyer, M.: Blood Concentrations and Clinical Studies With Chloramphenicol (Chloromycetin) Given Intramuscularly. American Federation of Clinical Research, May 1, 1951.

[4]MacCallan, A. F.: The Epidemiology of Trachoma. Brit. J. Ophth., 15:373, 1931.

[5]Lindner, K., in Berens: The Eye and Its Diseases. 2nd ed. Philadelphia, W. B. Saunders Co., p. 400, 1949.

Volvulus of the Sigmoid Colon*

H. E. Haymond, M.D.
Greeley, Colorado

VOLVULUS of the sigmoid colon constitutes one of the most major abdominal catastrophes encountered by the surgeon. Its relative infrequence in the practice of the average American surgeon taxes his clinical acumen to the utmost in arriving at the correct preoperative diagnosis, and further exercises his operative judgment in the proper treatment of the pathology revealed by laparotomy. Laurell (quoted by Bruusgaard) states that "volvulus means a torsion of the bowel on its mesentery which causes symptoms, whether the symptoms are caused by narrowing of the bowel, strangulation of the blood vessels, or both."

History

In 1830, the famous German pathologist, Rokitansky, classified intestinal obstruction and described rotation of the colon with occlusion. In the early years of the twentieth century, the surgeons around the Baltic Sea wrote extensively of their experience with the condition. Gatling and Kirby-Smith in 1948 found 105 references to this subject, and they pointed out that the small number of cases reported in each article indicated that few surgeons have the opportunity to observe many cases. In the past five years, there has been an increasing frequency of articles on the subject in the American and English medical literature.

Case Histories

In order that some of my readers might avoid the pitfalls that have been encountered in the treatment of three cases of volvulus of sigmoid colon in the Weld County General Hospital in Greeley, I would like to review briefly our experience. The first two cases are my own, and the third case is that of another surgeon who has kindly consented to my use of his clinical material:

Case 1: December 10, 1947. Male Sioux In-

*Read at the annual meeting of the Colorado State Medical Society, Denver, Colorado, October 2, 1953.

dian, 41; acutely obstructed twenty-four hours; treated by exteriorization of gangrenous sigmoid; died on fourth postoperative day of necrosis of the colon proximal to the colostomy, regional acute fibrinous peritonitis, and acute broncho-pneumonia of the right lung.

Case 2: June 25, 1948. White female, 28, college student; acutely obstructed twenty-four hours; treated by resection of the gangrenous sigmoid, closure of the distal rectal stump and end colostomy well above the gangrenous loop. Smooth, uneventful recovery with anastomosis of proximal and distal stumps at another institution at a later date.

Case 3: October 13, 1950. Spanish-American male, 65, deaf mute; partially obstructed with intermittent diarrhea for five days before admission; cecostomy attempted because of poor condition, with death twelve days later due to gangrene of sigmoid colon secondary to volvulus unrecognized until autopsy. Presumed cecostomy was actually a sigmoidostomy.

Mortality

The mortality of 66 per cent in our series of three cases of volvulus of the sigmoid colon with gangrene and infraction is not one to be proud of, but our experience parallels that of other surgeons reporting fatalities ranging from 30 to 50 to 66 per cent.

Etiology

There are certain factors that are quite well recognized in this condition. Volvulus of the sigmoid colon is usually seen in males (3 to 1). It is seen, as a rule, in patients over the age of 30. It is more common in geographical regions where the natives exist on coarse cellulose diets, as such diets apparently tend to elongate the gastrointestinal tracts. Relative to the preceding, Perlman reported a large series of cases arising around the Baltic Sea, and Delafield and his associates reported a series of seventy-eight cases among the Andean Indians in Peru. Its relative infrequence in the United States is indicated by Griffith, Bartron and Meyer from the clinical material in Cook County Hospital. They found an incidence of sigmoid volvulus in 8 per cent of large bowel obstructions and in only 2 per cent of all intestinal obstructions. It is always associated with anatomically predisposing conditions of the sigmoid itself such as a freely movable mesosigmoid and a long, freely movable sigmoid colon, the limbs of which lie close together.

Your speaker in 1935, in a review of 257 cases of massive resection of the small intestine, showed that a combined volvulus of the sigmoid colon and the small intestine called "knotenbildung" in the German, Finnish, Russian and Scandanavian literature, accounts for the greatest number (49) of reported cases of massive resection of the small intestine. In the review of the literature at that time and in the less extensive review for this paper, no mention of this condition was found in the English literature.

The classic symptoms of volvulus of the sigmoid colon are those of low intestinal obstruction with late vomiting and late distention of the abdomen. In many cases, there is considerable delay on the part of the patient to seek medical advice because of repeated similar previous episodes which have been relieved by self-administered enemas. In chronic cases, relieved spontaneously, Ligat and Overend call attention to a history of diarrhea *after* the abatement of the cramping abdominal pains *rather than during* the pains. In obstructive cases, a flat plate of the abdomen will reveal tremendously dilated loops of large bowel situated primarily in the right side of the abdomen. This distention in conjunction with an attempted barium enema below the associated sigmoid obstruction gives the so-called "ace of spades" appearance which has been described by roentgenologists. Bellini in 1949 reported a new radiologic sign of volvulus of the sigmoid colon when he pointed out that obstruction due to a sigmoid neoplasm dilates the loops of the ascending and descending colon to different diameters with the cecal region wider, whereas in sigmoid volvulus, the two segments of the distended coils show a uniform expansion and diameter inasmuch as they are segments of a single coil. Other writers have described a "duck's bill" deformity of the lower colon and still others have stressed the inability of the patient to receive more than 500 cubic centimeters of liquid as a measured enema. The severity of the low large bowel obstruction, the extent of the vascular embarrassment of the obstructed segment, and the duration of the pathological condition all contribute to the clinical picture of the victim when first seen by the surgeon.

Pathology

The constant pathology seen in a volvulus of the sigmoid colon is, of course, the torsion of an elongated loop of sigmoid around a narrow root of mesentery. The appearance of the loop of sigmoid may vary from simple edema and congestion to that of complete necrosis and gangrene. The highest mortality rates naturally are associated with the most extensive pathological changes.

Treatment

There is only one satisfactory curative treatment for either chronic or acute volvulus of the sigmoid colon, and that treatment is resection of the involved large bowel. This does not mean necessarily that the resection shall be carried out in a one-stage operation at an exploratory laparotomy.

Among the unsuccessful procedures that have been tried in the treatment of this dramatic condition, which are mentioned here only to be condemned, are: (1) Proximal decompression or cecostomy; (2) lateral anastomosis without resection; (3) detorsion of the sigmoid without a secondary operation for resection; and (4) any and all plastic or fixation operations on the sigmoid.

In chronic volvulus of the sigmoid colon, the non-operative treatment of inserting a rectal tube through a sigmoidoscope past the stricture to relieve the distention of the involved loop is merely a temporizing procedure; however, this rectal tube decompression procedure is probably more dependable than the haphazard use of enemas in the blind hope the bowel may be decompressed by spontaneous detorsion.

In acute volvulus of the sigmoid colon, the indications for laparotomy are clear cut after treatment for shock and the restoration of fluid balance, but the operative procedure is entirely dependent on the extent of the pathology encountered. With a viable sigmoid, detorsion and decompression by a rectal tube inserted at the time of operation may be accomplished at a primary stage. At a secondary stage, after the bowel has been properly prepared by antibiotics during a period to allow edema to subside locally, an end-to-end resection of the sigmoid may be performed. This conservative approach to the problem has been advocated by Bruusgaard, yet Delafield and his associates in Lima, Peru, immediately resected viable sigmoids in seventy-eight consecutive cases with no fatalities. They consider laparotomy less dangerous than manipulation.

With gangrene of the sigmoid, the nonviable bowel must be removed. In many papers, the Mikulicz exteriorization procedure has been recommended as the procedure of choice. This method of attack carries a high mortality as reported in the case series. It frequently is not possible or advisable because the point of torsion is too deep in the pelvis to allow safe delivery. Again, further extension of the necrosis may take place and not be recognized by the clinician. This will be remembered as the cause of death in Case 1 in our series. Bruusgaard believes that in gangrene of the sigmoid, resection of the necrotic bowel should be carried out with inversion of the distal stump and colostomy of the proximal part, followed at a later date with anastomosis of the proximal and distal stumps. This method was used successfully in Case 2 because it was impossible to exteriorize the colon for a Mikulicz resection, a maneuver that had only recently given us a fatality.

Summary

1. Three cases of volvulus of the sigmoid colon with gangrene are reported.

2. Signs and symptoms are described to assist in the earlier recognition of the disease so that the serious mortality rate may be reduced.

3. Curative treatment is obtained only by resection of the involved large bowel as indicated by the pathology encountered in each individual case.

REFERENCES

1. Bellini, M. Arias: Volvulus of the Sigmoid: A New Radiological Sign. Raadiology 53:268-270. (Aug.) 1949.

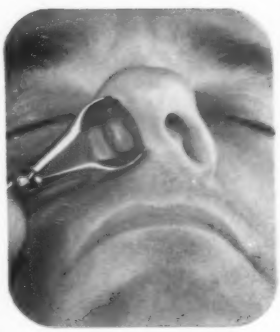
2. Bruusgaard, Christian: Volvulus of the Sigmoid Colon and Its Treatment. Surgery 22:466-478. (Sept.) 1947.

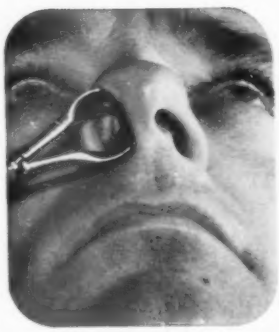
3. Clayton, Orville W.; Campbell, S. Joseph; and Guthrie, Robert F.: Volvulus of the Sigmoid Colon. American Surgeon 17:1101-1105. (Dec.) 1951.

4. Delafield, Robert H.; Hellriegel, Kurt; Meza, Amador; and Urteaga, Oscar; Sigmoid Volvulus. Review of Gastroenterology 20:29-36. (Jan.) 1953.

Ciba *products of performance*

Privine®





for nasal congestion in the common cold or allergy

THE PATIENT FEELS
a greater ease in breathing.

YOU OBSERVE
prompt reduction of turgid mucous membranes.

THE LITERATURE REPORTS
a rapid decongestive effect[1]—"relief lasts for several hours"[2]—and a prolonged reduction of local swelling and congestion.[2]

Supply: 0.05% Solution, 1 oz. bottle and 15 ml. Nebulizer.

1. Hild, A. M.: Schweiz. med. Wchnschr. 71:557, 1941.
2. New and Nonofficial Remedies, J. B. Lippincott Co., Philadelphia, 1953, p. 200.

PRIVINE® HYDROCHLORIDE
(NAPHAZOLINE HYDROCHLORIDE CIBA)

Ciba *Summit, N. J.*

2-10564M

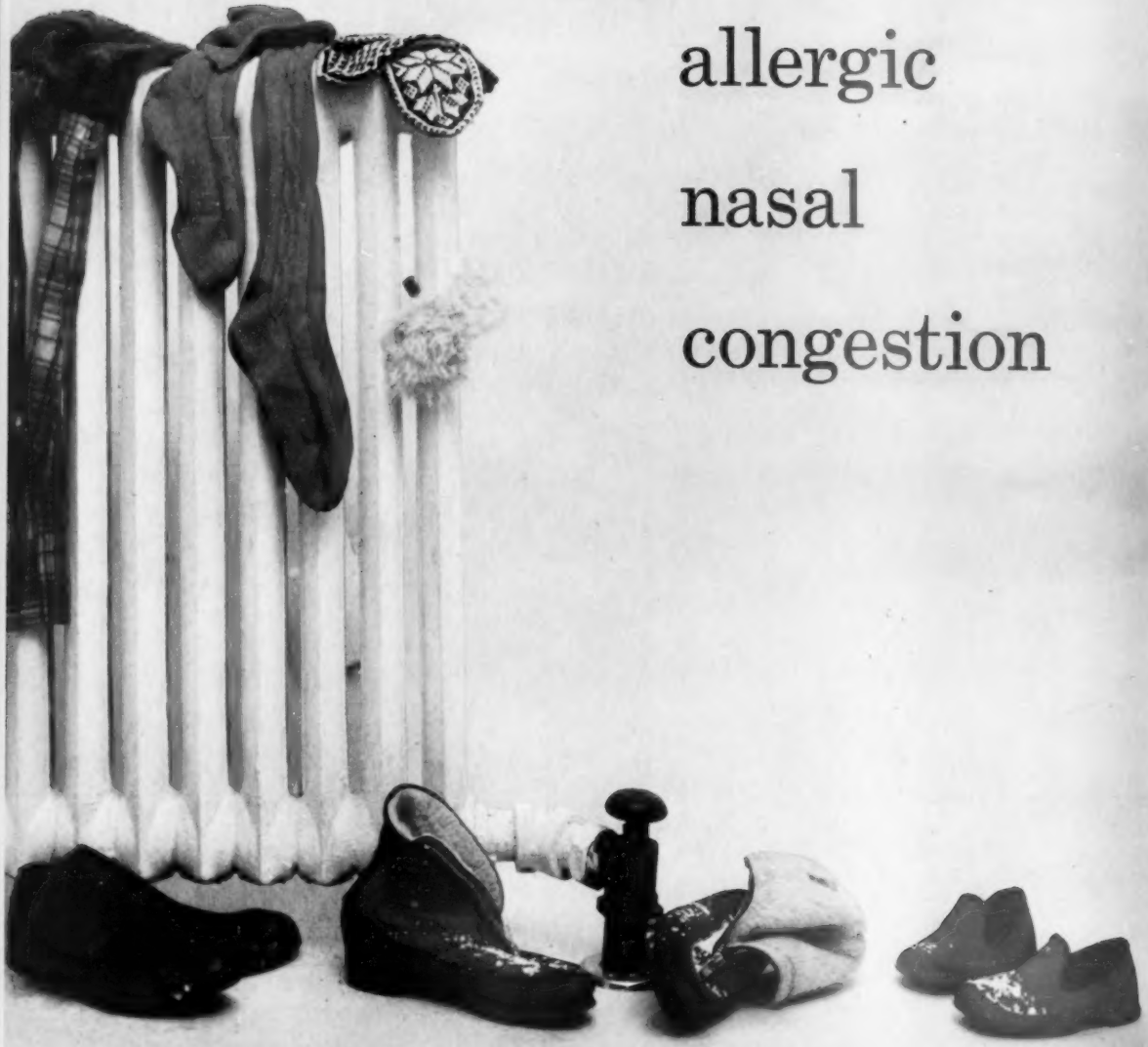
for

"off-season"

allergic

nasal

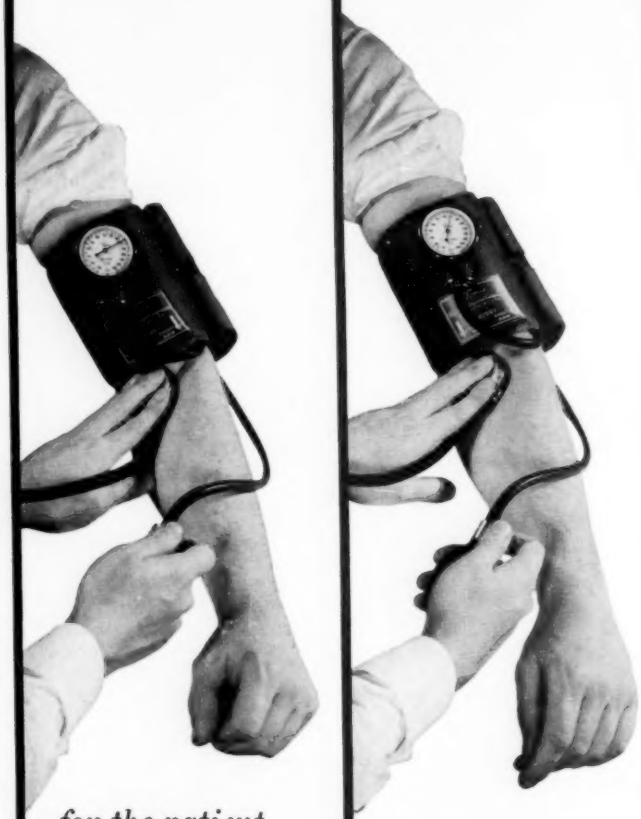
congestion



Ciba products of performance

Apresoline®

Apresoline



for the patient with moderate or severe essential hypertension

THE PATIENT REPORTS
progressive relief of hypertensive symptoms if present.

YOU OBSERVE
benefits in up to 80% of cases: e.g., hypertension gradually reduced, renal circulation improved, eye-ground changes may be reversed.

THE LITERATURE REPORTS
therapy is generally well tolerated with initial low dosages, gradually increased.[1,2,3] Patient response is the guide to dosage adjustment.[4] Optimal maintenance dosage level is usually reached only after 3 weeks or more; marked therapeutic effect cannot be expected with initial low dosages.[4]

Tablets of 10, 25, 50, 100 mg.
Ampuls of 1 ml., 20 mg.

1. Hafkenschiel, J. H., and Lindauer, M. A.: Circulation 7: 52, 1953.
2. Schroeder, H. A.: Circulation 5: 28, 1952.
3. Riven, S. S., Pocock, D. G., Kory, R. C., Roehm, D. C., Anderson R. S., and Meneely, G. R.: Am. J. Med. 14: 160, 1953.
4. Taylor, R. D., Dustan, H. P., Corcoran, A. C., and Page, I. H.: Arch. Int. Med. 90: 734, 1952.

APRESOLINE® HYDROCHLORIDE
(HYDRALAZINE HYDROCHLORIDE CIBA)

Ciba *Summit, N. J.*

2/1958M

5. Gatling, R. R., and Kirby-Smith, H. T.: Volvulus of the Sigmoid Colon. Ann. Surg. 128:1023-1027. (Nov.) 1948.
6. Griffin, William D.; Bartron, George R.; and Meyer, Karl A.: Volvulus of the Sigmoid Colon. Surg., Gyn., and Obst. 81:287-294. (Sept.) 1945.
7. Haymond, H. E.: Massive Resection of the Small Intestine. An Analysis of 257 Collected Cases. Surg., Gyn. and Obst. 61:693-705. (Nov.) 1935.
8. Ligat, D., and Overend, T. D.: Recurrent Volvulus of the Pelvic Colon. Brit. M.J. 2:7-10. (July 1) 1933.
9. Perlman: Arch. f. klin. Chir. 1925. Quoted by Clayton, Campbell and Guthrie.

Successful Resection Of Hepatoma*

PHILIP M. HOWARD, M.D., EDWARD P. GODDARD, M.D., and EDWIN R. MURPHY, M.D.
Salt Lake City

HEPATOMA of the liver is a rare condition. The diagnosis is usually made at operation or at postmortem examination. The first report of successful liver resection for adenoma was made by Keen in 1892, according to Wallace[1]. An eight-year follow-up revealed the patient to be alive and well. However, Stone and Saypol[2] report that Lucke in 1891 successfully removed a malignant tumor from the liver, primary carcinoma. Since the original reports there have been several additional articles concerning this subject. By 1915 there were sixteen cases reported in the literature[1]; since that time there have been sporadic cases reported, generally with disappointing results because of the magnitude of the surgical procedure. With better management of the problem of blood replacement and the use of the hemostatic substances, such as oxycel, gelfoam, etc., the scope of liver surgery has been broadened. Most successful attempts at liver surgery have been confined to lesions involving the left lobe; however, more recently extensive resections of the right lobe have been reported by Brunschwig and Wangensteen.

The procedure of hepatectomy has been performed for a variety of pathologic entities, including benign as well as malignant lesions, both primary and secondary. The benign lesions which have been resected include adenoma, hamartoma, cavernous hemangioma, and fibroma. Of the malignant variety hepatoma, cholangioma, angiosarcoma, and fibrosarcoma have been reported arising primarily in the liver. Recently Longmire performed a successful left hepatectomy and intrahepatic cholangiojejunostomy for stricture and obliteration of the common bile duct. It is because of the increasing resectibility of these liver tumors that we wish to report this case.

*From the Department of Surgery, Holy Cross Hospital, and the University of Utah College of Medicine, Salt Lake City, Utah.

CASE REPORT

The patient was a 4-year-old white male child who entered the Holy Cross Hospital, June 2, 1952, presenting a mass in the upper abdomen. In March, 1952, the patient complained of a vague abdominal pain, and the mother, on palpating the child's abdomen, discovered a mass just to the left of the midline in the upper abdomen. This was observed for a period of three months. The child had no other complaints and appeared in the best of health.

The past history was essentially negative except for the usual minor childhood illnesses and immunizations.

The family history was negative. The patient had two normal siblings.

Physical examination was essentially negative except for the presence of a round mass filling the epigastrium which moved with respiration. The mass was tender. The liver, spleen, and kidneys were normal to palpation.

Routine laboratory studies were normal. Flat plate of the abdomen revealed a soft-tissue mass in the epigastrium.

A preoperative diagnosis of congenital anomaly such as duplication of the stomach, cyst of the diaphragm or pancreas or tumor of the liver was made.

Operation: Under general anesthesia, using an upper left paramedian incision, exploration was performed with the following findings: There was a large spherical tumor involving practically the entire left lobe of the liver. The remainder of the abdominal exploration was negative. This mass was approximately eight to ten centimeters in its maximum diameter and of yellow-brown color. A biopsy was taken for frozen section and reported to be a possible adenoma of the liver. Because of its localization in the left lobe of the liver, it was elected to do a partial hepatectomy, removing the tumor mass in its entirety.

The left lobe of the liver was mobilized by incising the coronary and triangular ligaments and brought out through the abdominal incision. Two parallel rows of overlapping mattress suture ligatures were started to the left of the quadrate lobe in the region of the ligamentum teres. These were of No. 0 braided black silk. The liver was then incised between these sutures. As the excision of the left lobe progressed, the left hepatic artery was isolated in the hilum and individually ligated. This effected hemostasis remarkably, and it was only necessary to place one row of mattress suture ligatures; the left lobe could be compressed manually to prevent retrograde bleeding. Several ligatures were placed in addi-

tion to the mattress stitches to complete hemostasis. An attempt was made to locate the left hepatic duct, but this was not found, and it was presumed to be compressed by the mattress sutures. Gelfoam was placed along the line of excision to control a slight ooze, and a soft Penrose drain was brought out through a separate stab wound in the left upper abdomen. The abdominal wall was closed with interrupted figure of eight No. 32 stainless steel wire sutures and No. 35 stainless steel wire on the skin and subcutaneous tissues. Five hundred c.c. of whole blood was given during the procedure. The child withstood the operative procedure well.

The postoperative course was uneventful, and the patient was discharged from the hospital nine days following the operation.

Pathology: Gross—The left lobe of the liver including the tumor measured 12 x 7 x 5 cm. On the surface there appeared to be a tumorous enlargement approximately 8 cm. in maximum diameter. On sectioning this mass a yellow-brown fairly well circumscribed neoplasm was seen, which was felt to be either an adenoma or carcinoma. The tumor was soft in consistency and the capsule thin and irregular.

Microscopic—The surrounding liver tissue was normal. The tumor was made up of liver cord cells resembling that of the liver adjacent to it. However, fatty degeneration was present in the former. Mitotic figures were not prominent in the tumor cells, and the nuclei were quite regular. Some areas were marked by central degeneration and hemorrhage.

It was the opinion of the pathologist that the fatty degeneration did not represent evidence of one of the lipoid or glycogen storage diseases. The diagnosis was a non-functioning adenoma of the liver.

Technical Considerations

The major problem in liver resection is the management of hemorrhage. The smaller tumors involving the right and left lobes of the liver can be successfully handled by wedge excision and approximation of the cut edges. However, in dealing with larger tumors such as those involving the entire left lobe of the liver or major portions of the right lobe, it is imperative that hemostasis be secured by the preliminary placing and tying of overlapping mattress sutures. In performing a left lobe hepatectomy excision is facilitated by division ot the falciform and triangular ligaments, which adequately mobilizes the left lobe. As was done in this case, the hepatic artery at the hilum of the liver should be isolated and individually ligated. Wangensteen suggests temporary occlusion of the afferent blood supply of the liver in order to produce a bloodless field in extensive resections of the right lobe. A row of overlapping mattress sutures, usually of black silk, can be placed along the line of excision at the interlobar sulcus. A parallel row of similar sutures can be placed approximately one-half inch distal to the first row, or, bleeding from the excised specimen be controlled by manual compression during the procedure. As the resection progresses, individual bleeding points may be clamped or clipped; or additional mattress sutures may be taken to complete hemostasis. Any of the larger bile ducts encountered should be individually ligated. Following the resection, as an added precaution gelfoam or oxycel strips may be placed over the raw liver surface. Drains should be placed down to the site of resection to prevent bile peritonitis.

The operative approach is made depending upon the size and location of the suspected liver mass. Paramedian and subcostal incisions have been found satisfactory for excision of the left lobe. However, in tumors involving the right lobe, a combined thoraco-abdominal incision is preferable. One of us (P. M. H.) has used the inverted V subcostal incision described by Longmire with adequate exposure for hepatectomy and intrahepatic cholangiojejunostomy.

Discussion

Investigation of the literature on the subject of hepatic tumors revealed the most workable classification and complete description in Ewing's Textbook of Neoplastic Diseases[3].

The classification is as follows:

Simple hypertrophy and hyperplasia:

1. Regeneration.
2. Congenital solitary hyperplasia.
3. Nodular hyperplasia.
4. Diffuse hyperplasis.

Neoplastic hyperplasis:

1. Hepatoma:
   a. Adenoma.
   b. Adenocarcinoma.
   c. Carcinoma.
2. Cholangioma:
   a. Adenoma.
   b. Adenocarcinoma.
   c. Carcinoma.
3. Mixed tumors.

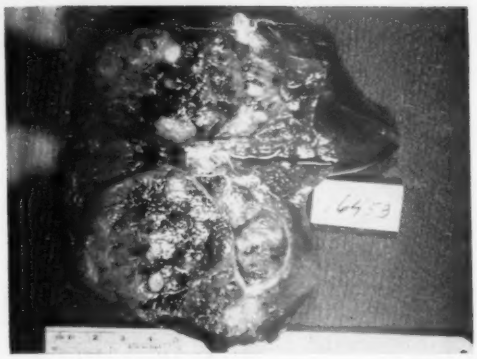


Fig. 1 Photograph of the gross specimen showing the excised left lobe of the liver containing the tumor.

Willis is of the opinion that these tumors of infancy and childhood are embryonic in origin[4]. Wells, however, in his monograph concerning congenital malignant neoplasms, states that one must be skeptical of all lesions cited as congenital carcinoma of the liver, since there are few, if any, proved to have been present as carcinoma at birth[5]. It is felt by others that this type of tumor is included in those referred to as hamartomas, a term introduced into literature by Albrecht in 1904 to include certain vascular tumors of the liver, congenital malformation and developmental defects[6].

The case under discussion would be included in the group of hepatomas of a benign nature. From the above classification it can be seen that these tumors may be of hepatic or biliary duct origin or of a combination of the two tissues. In 85 per cent of primary epithelial tumors cirrhosis is concomitantly present, and another predisposing factor is felt to be biliary stasis, according to Ewing.

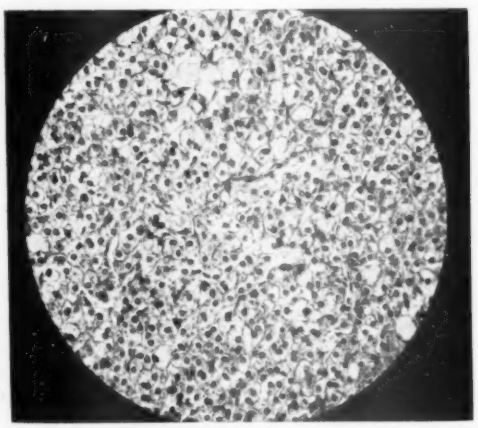


Fig. 2 Photomicrograph illustrating the histologic structure of the excised hepatic tumor.

Histologically these tumors of hepatic origin consist of hypertrophied liver cord cells, which gradually change from the normal granular type to a more basic-staining variety. There appear nuclear hypertrophy and hyperchromatism. Giant and multinucleated cells are present. Later the cells become smaller, as found in this case.

The cholangiomatous forms of the tumor are rare; however, there may be, as stated above, a combination of this with the liver-cell type. In the tumors of bile-duct origin the histologic picture resembles that of normal thyroid tissue. The above-described tumors may undergo malignant transformation and would then be classified as carcinomas. However, these benign tumors, if not extirpated, are clinically malignant, because of the replacement of normal liver tissue by a non-functioning tumor.

Summary

1. Case report of a successfully excised primary tumor of the left lobe of the liver is presented.

2. Technical aspects of hepatectomy are reviewed.

3. Discussion of the pathologic classification of liver tumors and the histologic description of benign hepatomas are considered.

REFERENCES

[1] Wallace, Richard H.: Resection of Liver for Hepatoma. Arch. Surg., 43:14-20, 1941.

[2] Saypol, George M., and Stone, Peter W.: Partial Hepatectomy, Presentation of Four Cases and Discussion of Technic. Surg. Gyn. Obst. 95:191-200, 1952.

[3] Ewing, James: Neoplastic Diseases, ed. 4, Philadelphia, W. B. Saunders Company, 1942, 735-753.

[4] Willis, R. A.: Pathology of Tumors, London, Butterworth and Co., 1948, 932-935.

[5] Wells, H. Gideon: Occurrence and Significance of Congenital Malignant Neoplasms. Archives of Pathology, 30, 535-601, 1940.

[6] Hamilton, F. E., Colonel M.C., U.S.A., and Holmes, R. H., Lt. Colonel, M.C., U.S.A.: Cavernous Hemangiomia of Left Lobe of Liver. Armed Forces Med. J. 1:443-446.

Utah Tumor Registry—First 1,000 Cases*

E. J. Eichwald, M.D., J. H. Carlquist, M.D., and A. A. Jenkins, M.D.
Salt Lake City

THE Utah Tumor Registry was established in 1951. Its purpose is to obtain a true picture of cancer morbidity in Utah residents, and to serve as a case finding mechanism for epidemiological, clinical and teaching purposes.

Tumor registries have been established in several states: Connecticut, Kentucky, Alabama and others. Cancer morbidity in several American cities has been studied by the UHPHS by utilization of hospital and related records. Also, in the State of Utah, cancer has been a reportable disease since December, 1947. The yield from these efforts often has been limited, and has fallen short of giving a true picture of cancer morbidity in a large geographical area. In some of these attempts too much reliance has been placed on the continuous and active support of already overburdened hospital record librarians or practicing physicians. In others, one or several large hospitals have been unwilling to participate. Thereby they have largely annulled the significance of any results from an epidemiological point of view. Again in other instances the expense of the upkeep of a registry has seemed inordinately high when measured against the actual or potential yield.

The situation in Utah has presented several unique features which portended well the establishment of a successful and inexpensive registry. Since cancer is a reportable disease, a framework had already been established to develop the Registry in extension of the services of the State Department of Health. The Utah State Medical Association, the Utah Chapter of the American Cancer Society and the Utah Radiological Society have supported the Registry since its onset. The pathologists in the state, organized in the Utah Association of Pathologists and closely linked to the University of Utah College of Medicine, have without exception made their material available to the Registry. Through the student body of the College of Medicine there has been available a group of young men willing to do the groundwork for the Registry at relatively small pay.

Several additional circumstances have contributed to the initial success of the Utah Tumor Registry: 71 per cent of the state's population and 78 per cent of the hospital beds are located within a radius of forty-five miles. All major hospitals and laboratories are located within this area. The population of the state is relatively stable. In accordance with the unusual history and social structure of the state, there has been a good deal of interest in genetic and related problems of concern to the welfare of the community. Furthermore, pioneer work for the establishment of a Registry had been done by a highly respected Ogden physician who had been active in cancer work for a long time, Dr. Ernest Mills. The plans were readily taken up and developed by Dr. Garth Edmunds, then in charge of the cancer program of the State Department of Health.

Method of Obtaining Data

The data are obtained by a medical student employed as a part-time "Field Registrar." The Field Registrar visits at regular intervals (two to four weeks) the record rooms and pathological laboratories of all major hospitals, the State Department of Health and the private laboratories. He initiates a registry form for every Utah resident in whom the diagnosis of malignant disease has been made. The data are filed by diagnosis and alphabetically by a part-time clerk. As a check, cancer death data are obtained once annually from the Office of Vital Statistics of the Utah State Depart-

*From the University of Utah College of Medicine.

ment of Health. This method of case finding carries in itself an automatic partial follow-up, since the majority of cancer cases are encountered more than once in either hospitals, laboratories or the Office of Vital Statistics.

The First 1,000 Cases

The data in Tables 1-2 present several interesting features. They represent roughly the yield of the first year of the Registry. As usual in present-day cancer morbidity statistics, the parade is led by the "Big Three," cancer of the bowel, the breast and the skin (Table 1). This will be a surprise to some who believe, under the impression of (faulty) mortality statistics, that the stomach is the most common site of cancer in man. The stomach occupies the eighth place; this is about national average, except in northern cities where it exceeds in frequency cancer of the prostate and the blood-forming organs. The high incidence of lymphomas and leukemias also is noteworthy: they are more common than cancer of the prostate, the stomach and the lung. The incidence of most cancers in Utah is similar to that reported in other U. S. areas. With respect to cancers which are more frequent in the South (lip, skin) or the North (stomach, lung, breast), Utah holds approximately an intermediate position.

There are, however, several cancers whose incidence in Utah differs from that in other regions from which comparable statistics are available. This is demonstrated in Table 2. Cancer of the female genital tract is less common than has been reported from other areas. This applies to cancer of both the uterus and the ovaries but is more impressive in the former because of the generally higher incidence of uterine cancer. It is essentially a low incidence of cervical cancer as indicated by the low ratio of cervical to fundus cancer. This ratio in Utah is 1.2, as compared to Chicago (5.8), Detroit (8.8), Birmingham (6.3) or Dallas (6.0). Since cervical cancer is more common in the Negro than the white female (white/non-white ratio in Chicago, 0.69; Detroit, 0.65; Birmingham, 0.68; Dallas, 0.67), one might ask whether the low ratio in Utah is explained by the small Negro population (0.4 per cent). This is not the case. When the cervix/fundus ratio in Utah is compared with that of only the white population in these four areas the difference still remains impressive: 1.2 in Utah, as compared to 5.0, 4.2, 4.5, and 5.1 in the other areas. This is the more surprising since early marriage and multiple childbirths, factors thought to contribute to the development of cervical cancer, are believed to be more common in Utah than in many other American regions.

TABLE 1.

Organ Incidence of First 1,000 Cases of Tumor Registry in Order of Frequency (per cent)

1. Bowel	13.9
2. Breast	13.7
3. Skin	12.8
4. Uterus	7.8
5. Lymph nodes, blood	6.8
6. Prostate	5.9
7. Lung	4.7
8. Stomach	4.7
9. Bladder	4.1
10. Primary unknown	4.1
11. Kidney	2.3
12. Pancreas	1.9
13. Ovary	1.8
14. Lip	1.7
15. Malignant melanoma	1.7
16. Liver, bile ducts	1.6
17. Tongue, salivary gland, mouth	1.6
18. Larynx	1.3
19. Brain, meninges	1.3
20. Thyroid	1.1
21. Male genital tract, except prostate	1.0
22. Bone	0.9
23. Pharynx, sinuses	0.8
24. Other	2.5

TABLE 2.

Cancers Whose Incidence in Utah Differs From That Reported for Other Areas (in per cent of Total Reported Cancers)

	Utah	Chicago	Detroit	Birmingham	Dallas
Uterus	7.8	11.2	13.3	16.6	12.5
Ovary	1.8	2.5	2.5	2.2	2.1
Others	0.6	0.6	0.8	0.9	0.5
Total Female Genital Tract	10.2	14.3	16.6	19.7	15.1
Bladder	4.1	4.0	3.4	1.7	1.9
Kidney	2.3	1.4	1.5	0.8	1.1
Prostrate	5.9	4.2	4.5	3.0	4.1
Blood, Lymph Nodes	6.8	5.3	6.3	5.1	6.1
Same, excl. Hodgkin's D.	6.1	4.1	4.9	3.9	4.6
Bowel	13.9	13.3	12.7	6.7	6.0

By contrast cancers of the male genital tract (prostate) and the urinary tract (bladder, kidney) appear to be more common in Utah than in the areas with which comparison has been made in this report (Table 2). The high incidence of bladder and renal carcinoma can be explained on the basis of the small Negro population: both tumors are more common in whites, the white/non-white ratio of bladder cancer being approximately 2.9 and that of renal cancer 1.4 in other areas. It cannot explain the high incidence of prostatic cancer, since the white/non-white ratio of this disease is about 0.75. Any correction for racial distribution would only emphasize the observed difference.

Lymphomas and leukemias also appear to be more common in Utah than in the comparison areas, particularly when Hodgkin's disease is eliminated from this group. This high incidence cannot be explained by the fact that Salt Lake City is an internationally known center for the management of blood diseases since care was taken to include in the Registry only residents of the state.

Bowel cancer is absolutely and relatively common in Utah. It appears to exceed that reported for the Northern cities, and more than doubles that in Southern cities.

Critical Analysis

The data in Table 1 are not wholly representative of cancer morbidity in several respects. Not all cases are "first diagnoses." This flaw will automatically disappear in successive years. Also, the yield is not yet complete. While some of these deficiencies can be corrected in the near future, others cannot in a forseeable time.

At present the most obvious deficiency lies in the fact that not all cancer cases are hospitalized at one time, nor is material being submitted for pathological diagnosis. This applies most commonly to skin cancers which at times are removed in the office by means not permitting pathological diagnosis (electro-cautery, etc.), or are discarded to save the patient expense. Cancers which are removed in small hospitals which do not utilize the services of a pathologist also escape the registry. These two deficiencies will in large part be done away with by annual visits to the small hospitals not covered at present and by visits with the offices of dermatologists who see a large number of skin cancers.

There are two deficiencies which can only be corrected by a general improvement of medical services: data from patients who die without medical attendance (in outlying districts, etc.), and data from patients in whom the diagnosis is missed or made incorrectly.

Summary

The background and the methods of the Utah Tumor Registry are described. It is explained how important cancer morbidity data are obtained from a large geographical area, and at relatively low cost. Leads have been found which suggest that cancer of the cervix is rare in Utah in comparison to other areas, while cancer of the prostate is relatively common.

Miami Society Conducts Plaque Poll

Universal display of the A.M.A. plaque, "To All My Patients," in doctors' offices was recommended by the majority of the Miami, Florida, physicians responding to a recent informal poll conducted by the Dade County Medical Association. Many favorable comments on the plaque were received from physicians, whereas only one doctor gave a definitely unfavorable response. Typical patient comments noted by these physicians ranged from "a good idea" to "glad to see we have a humanitarian amongst the profession." Only one doctor reported a negative patient response which implied that medicine is "becoming too commercialized."

This poll brings out the fact that most patient fee questions concern the cost of doctors' services, the cost of hospital services, making arrangements to pay doctor bills and insurance. From the doctor's point of view, the discussion of fees was indicated to be "easy" by 42 per cent of the group, "relatively easy" by 35 per cent, "fairly difficult" by 15 per cent and "difficult" by only 8 per cent. The questionnaires were distributed to 112 physicians—representing a cross section of the medical society membership—about a month after some 1,000 plaques had been distributed free by the local society.

To help practicing physicians create better relations with their patients, the American Medical Association is continuing to offer this plaque for one dollar, postpaid. Direct your requests for the plaque to the Order Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois, or to your own State Medical Society's secretary.

Clinical Results* with Banthine® Bromide

(Brand of Methantheline Bromide)

22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	28
Friedmon	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Grunlund, Tobiassen	26	26	21			5	16	4	6				9	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	20			18[6]	27	7	4[7]				10	2	5	21
Meyer, Jorman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Bassett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	1443	960	1380	17	8	38	1142	122	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3		2.7	3.7	70.5	6.6	22.9	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

G. D. Searle & Co.
P. O. Box 5110, Chicago 80, Illinois

The Washington Scene

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

Some parts of the Eisenhower administration's broad health program are making good progress on Capitol Hill, while others are virtually standing still or bogged down in the technical complications that are always a threat to new legislation. Well ahead of the other proposals, and possibly destined for enactment, are bills to broaden the scope of the Hill-Burton hospital construction law and to liberalize income tax deductions for medical expenses.

The House Interstate and Foreign Commerce Committee, under chairmanship of Rep. Charles Wolverton (R., N. J.), wound up its long fact-finding study of voluntary health insurance plans and immediately started hearings on the Hill-Burton changes. The purpose is to amend the Hill-Burton law so that it can be used to disburse federal grants to states for construction of health facilities that do not qualify as "hospitals." The administration is anxious to stimulate the building of more nursing homes, hospitals for the chronically ill, diagnostic or treatment centers and rehabilitation facilities.

An initial appropriation of $2 million would be authorized for surveys and planning, and $60 million annually for three years of construction. Per capita income as well as population would be used to determine a state's share, as under the present Hill-Burton program.

At the House hearing, crowded into two days, the construction program was indorsed at least in principle by every witness, except the representative of the American Association of Nursing Homes. Because the program is limited to non-profit sponsors, members of this group could not receive grants. Their spokesman said long-term loans through the Small Business Administration would help solve their problem.

American Medical Association recommended passage of the bill, but urged that facilities for the chronically ill and the handicapped be "part of or near a conventional hospital," and that facilities of all types be open to the entire community without discrimination, as in the present Hill-Burton law. (It is likely hearings also will be held on this legislation in the Senate.)

The House Ways and Means Committee, meanwhile, was giving its approval to a new income tax provision that would allow the deduction of medical expenses if they exceed 3 per cent of adjusted gross income, rather than 5 per cent under present law. The present maximum limitation would be doubled, and the deduction of travel expenses allowed where travel is prescribed by a physician. These changes—a long-time AMA goal—are embodied in the omnibus tax readjustment bill.

President Eisenhower's proposal for federal reinsurance of voluntary health plans has not been able to follow the steady course on which it first appeared to be embarked. At the House hearings, none of the spokesmen for the large organizations in the health fields—AMA, Blue Cross and Shield, American Hospital Association—was willing to indorse the plan. Like the AMA spokesmen, most of them wanted first to examine the actual administration bill, which at that time had not been introduced. From the Blue Cross, however, came a suggestion that the idea be tried out experimentally.

Spokesmen for national labor organizations expressed mixed reactions, with some maintaining that reinsurance was a poor substitute for what they believe the country really needs—national compulsory health insurance.

The administration's health budget for the next fiscal year, starting next July 1, calls for a slight overall reduction. The regular Hill-Burton program, currently operating on $65 million, would get $50 million (any appropriation to start the proposed expanded construction would be in addition). Relatively sharp reductions would be made in funds for venereal, tuberculosis and communicable disease control, in line with the policy of shifting this responsibility to the states. The various research institutes would receive about what they are now spending.

One of the few new items is for $7.8 million, estimated as necessary for the extra cost of enlarging the federal program of vocational rehabilitation. Legislation authorizing the expansion is awaiting Congressional action. The administration hopes gradually to increase the number of persons rehabilitated annually from the current 60,000 to 200,000. While the program is being stepped up, one of its goals would be to induce states to increase their spending until eventually their appropriations match the federal. Like most of the President's health program, the rehabilitation effort has the support of the AMA.

Conferences between AMA officials and administration leaders are continuing. Latest sessions were with Secretary Hobby, concerning her department's legislative plans; with VA Administrator H. V. Higley, on treatment of non-service connected cases; and with Admiral Arthur W. Radford, chairman of the Joint Chiefs

of Staff, Dr. Frank Berry, Assistant Defense Secretary for health and medical matters, and Dr. Howard A. Rusk, chairman of the Health Resources Advisory Committee, on medical care for military dependents. Representing the AMA at one or more of the meetings were Drs. Walter B. Martin, David B. Allman, Gunnar Gundersen, Louis Orr, James C. Sargent, W. L. Crawford, George F. Lull, Ernest B. Howard and Frank E. Wilson.

Earlier, AMA representatives talked over legislation with President Eisenhower at the White House.

National Affairs

Foreign-trained Doctors Creating U. S. Problem

Licensure and medical care problems created by the heavy influx of foreign-trained doctors commanded a great deal of attention at the 50th annual Congress on Medical Education and Licensure, held in Chicago, February 7-9. The three-day meeting attracted more than 600 medical educators and licensing and specialty board officials. The congress was sponsored by the American Medical Association's Council on Medical Education and Hospitals, the Federation of State Medical Boards of the United States and the Advisory Board for Medical Specialties.

"The infiltration of the medical profession of the United States by large numbers of doctors who have not been able to obtain a proper basic professional education is almost certain to lower the general level of practice in this country," Dr. Willard C. Rappleye, New York, Dean of Columbia University College of Physicians and Surgeons, told the meeting. "The numbers coming in are so large that they cannot readily be absorbed without that effect."

Dr. Rappleye pointed out that the United States government, in fostering international good will, is admitting large numbers of displaced persons, including physicians about whose professional ability no questions are asked. More will be admitted by recent legislation which permits the entrance of several hundred thousands of immigrants above previous quotas, he said.

He added that unless this situation is met "with courage and the conviction that we shall not surrender the results of forty years of effort in raising the standards of medical licensure, practice and education," we may revert to conditions resembling those of fifty years ago.

Dr. Stiles D. Ezell, Albany, Secretary of the New York Board of Medical Examiners, also called attention to the inadequacy of the medical training of most of the foreign doctors seeking to practice in the United States. Dr. Ezell said that except for Great Britain and the Scandinavian countries the last war brought destruction and degeneration to European medical education.

Dr. Edward L. Turner, Chicago, Secretary of the Council on Medical Education and Hospitals, recommended the adoption of a uniform plan for screening the professional competence of foreign-trained doctors.

Such a uniform procedure, Dr. Turner said, would be of greater assistance to state medical licensing boards than the present attempts to evaluate and list foreign medical schools. He pointed out that there are problems and difficulties in evaluating foreign medical schools which are "almost insurmountable."

Dr. Edward J. McCormick, Toledo, president of the A.M.A., told the meeting that it was the responsibility of medical educators to instill a proper sense of moral values into the minds of medical students.

"Whether this is done by adding courses in ethics and moral principles to the curriculum, or through the medium of after-hours discussion groups, is a problem for the deans of medical schools to decide," Dr. McCormick said. "But, I am convinced that some concerted effort in this direction needs to be made."

The financing of medical education was touched upon by two speakers. William C. Stolk, New York, President of the American Can Company and a trustee of the National Fund for Medical Education, reported that management is becoming alert to the vital significance of the seventy-nine medical schools. Mr. Stolk said that business is accepting increased responsibility in helping to maintain high health standards and it realizes that financially solvent medical schools are a necessity.

Dr. Louis H. Bauer, New York, President of the American Medical Education Foundation, said that physicians contributed $1,090,771 to the foundation in 1953, passing the million-dollar mark for the first time. The 1954 goal was set at $2,000,000. There were 17,809 individual contributions last year, an increase of 149 per cent over 1952, Dr. Bauer reported.

A fast-growing interest in postgraduate education was reported by Dr. Douglas D. Vollan, Chicago, a staff member of the Council on Medical Education and Hospitals. Presenting a preliminary report of a survey of postgraduate education by the council, Dr. Vollan said that responses from about 5,000 physicians out of 17,000 chosen at random indicated that they

spent an average of 83.3 eight-hour days a year in keeping themselves up to date.

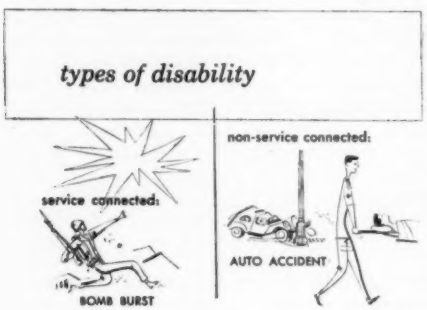
A panel on professional orientation brought out general agreement that most medical school graduates enter active practice with inadequate preparation and training in ethics, medical economics, doctor-patient relationships and social problems. Medical schools have the primary responsibility of providing such teaching, the panel members concluded, but they should have the help of medical societies and physicians in active practice.

Medical societies have a definite responsibility to sponsor and advance postgraduate education in order to improve the caliber of medical service to the public, it was emphasized by one panel member. Another urged that teachers of postgraduate courses should have adequate previous experience to appreciate the needs of active practitioners. A third participant suggested that there is a rich area for experimentation in the field of home-study courses. There was general agreement on the need and value of participative courses which enable postgraduate students to work closely with teachers and patients in the demonstration of clinical problems.

The distribution of physicians in the United States is extraordinarily good, according to Frank G. Dickinson, Ph.D., Chicago, director of the A.M.A. Bureau of Medical Economic Research, who made a preliminary report of a seven-year survey based on a division of the country into 757 trading areas.

Dr. Dickinson reported that every town with a population of more than 5,000 had at least one physician in active practice, as had 96 per cent of those with a population between 2,500 and 5,000; 88.3 per cent of those with a population of between 1,000 and 2,500, and 21 per cent of those with a population between 100 and 1,000. More than half of the latter group had less than 250 inhabitants. Only one-sixth of one per cent of the population lived outside a 25-mile radius of the closest town with a physician in active practice, he said.

In Viewing the VA Medical Program . . .



The medical profession fully endorses and supports the medical program of the Veterans Administration through which veterans receive medical care and hospitalization without cost for illnesses or injuries incurred as a result of military service (left). It is felt, however, that the federal government should not assume the responsibility for the medical care of veterans whose disabilities are incurred in civilian life and which have no relationship to their military service.

The Real Story Of American Medicine

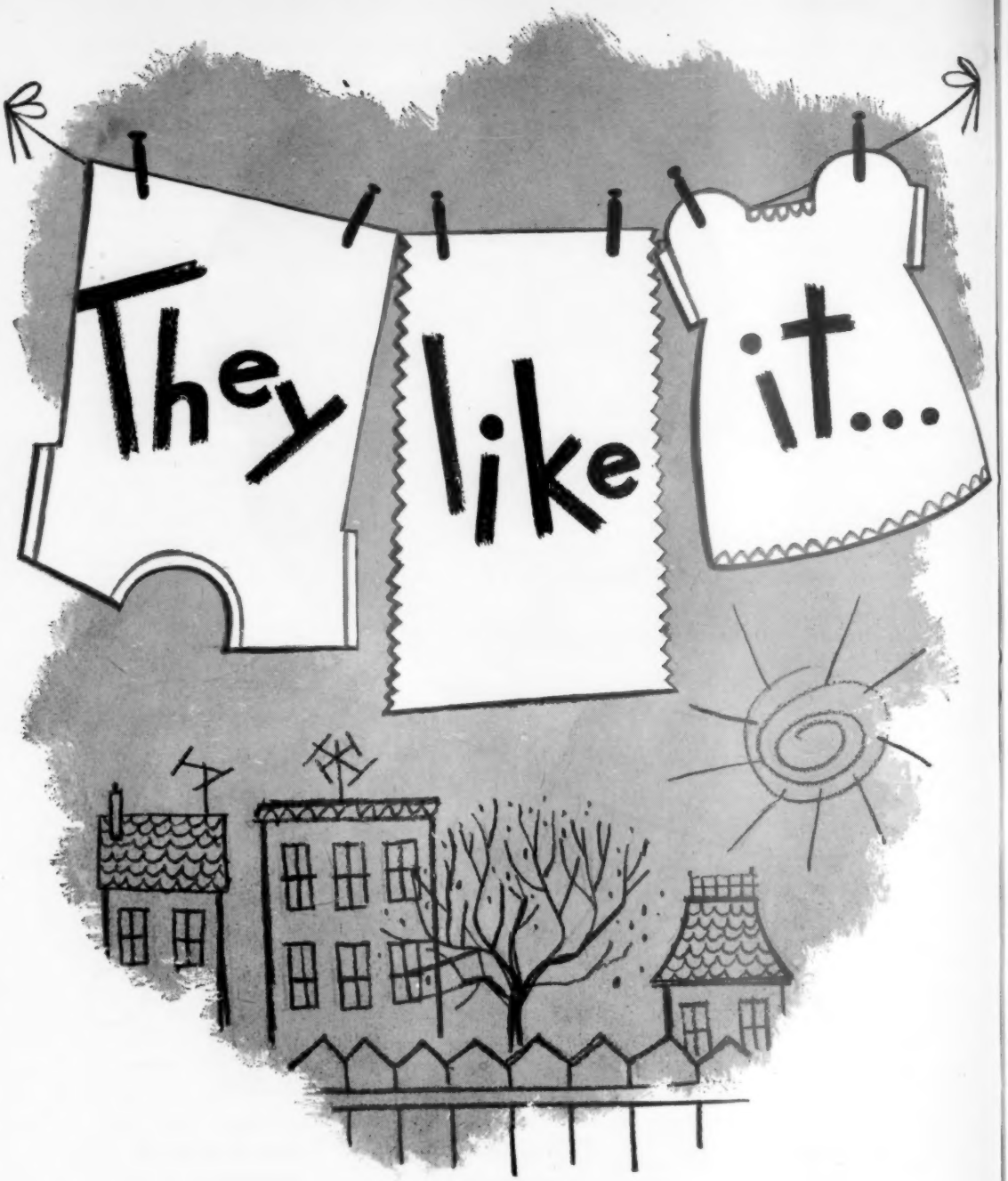
The amazing growth of medical care and health services in recent years are capably outlined in a recent statement delivered by Dr. Walter B. Martin, of Virginia, President-elect of the American Medical Association, before the House Committee on Interstate and Foreign Commerce. Dr. Martin's factual, hard-hitting testimony gives the lie to those who periodically proclaim that the American people do not receive adequate medical care, that it is high priced, and that there is a shortage of physicians.

Dr. Martin, early in his testimony, said that the American Medical Association would be the first to admit that despite the remarkable record of medical achievement much remains to be accomplished. He then emphasized that in practically every instance of recognized deficiency the American Medical Association has been the first organization to undertake a constructive program of action.

Here are some of the highlights of his testimony:

1. Statistics presented by the United States Department of Labor for the third quarter of 1952 revealed that living costs had increased 90.8 per cent since 1935-1939 while medical costs increased only 65.5 per cent in the same period. Between 1935-1939 and 1950 average weekly wages rose 165 per cent while physicians' fees were up only 48 per cent. A survey completed for the Federal Reserve Board last year showed that of 53,000,000 families in the United States, almost 43,000,000—over 80 per cent—reported no medical debts whatsoever. One million owed from $200.00 to $1,000.00, while another 200,000 owed more than $1,000.00 This would indicate that less than 3 per cent of the people included in the survey needed help to pay their medical expenses.

2. Every now and then someone claims a serious shortage of doctors exists, and actually we have more doctors than any other nation. We


They like it...

Cinnamon-flavored,

ready-mixed form of the new antibiotic

. . . stable 18 months . . . administer any time

It's tasty. It's stable. It's *Pediatric* ERYTHROCIN Suspension—made especially for little patients. Rich in cinnamon flavor, *Pediatric* ERYTHROCIN has a sweet candy-like taste that children really like.

And it works. Against common winter coccal infections. Against pyoderma, erysipelas, and other infectious conditions. Especially advantageous against staphylococci—because of the high incidence of staphylococcal resistance to many other antibiotics and when the patient is allergically sensitive to other antibiotics.

Gastrointestinal disturbances rare. *Pediatric* ERYTHROCIN is specific in action—*less likely to alter normal intestinal flora than most other antibiotics.* No serious side effects reported.

Pediatric ERYTHROCIN comes in 2-fluidounce, pour-lip bottles. *No mixing required.* Can be administered before, after or with meals. Prescribe *Pediatric* ERYTHROCIN. Abbott

pediatric

Erythrocin

TRADE MARK

stearate

(Erythromycin Stearate, Abbott)

Oral Suspension

DOSAGE

One 5-cc. teaspoonful represents
100 mg. of ERYTHROCIN
25-lb. child—½ teaspoonful
50-lb. child—1 teaspoonful
100-lb. child—2 teaspoonfuls
Every 4 to 6 hours

5-06-64

have more doctors in proportion to population than any country except Israel which has an abnormal influx of refugee physicians from Europe. For more than twenty years the number of physicians has been increasing at a faster rate than the general population. It is estimated that 1950-1960 will bring another 30 per cent increase in the supply of physicians. Today we have a total of 220,104 physicians—the largest in our history. Of this number 159,120 are in active practice, so on the basis of an estimated population of 160,000,000 in 1953 we now have one physician for every 727 persons or approximately one physician actually in practice for every 1,000 persons. For the fifth consecutive year, the total number of students enrolled in our medical schools has established a new record and the number of students graduated constitutes the largest number ever graduated in one academic year. Enrollments in the country's seventy-two medical and seven basic science schools during 1952-1953 totaled 27,688—up 23 per cent from the previous year. The estimated number of graduates for 1953-1954 is 6,831—up 4.4 per cent over a year ago.

3. Today America is the healthiest large nation in the world. Babies born today can expect to live at least twenty years longer than those born in 1900. Women can face childbirth with little or no fear, for the chances of surviving pregnancy, childbirth and confinement are better in the United States as a whole than 999 out of 1,000. The dread diseases that once were killers—typhoid, smallpox, diphtheria, pneumonia and many others, have been brought under control. Since 1900, while our total population has more than doubled, the number of persons 65 years of age or older has more than quadrupled. This accounts largely for the marked rise in the death rates for heart disease, cancer and other diseases of old age.

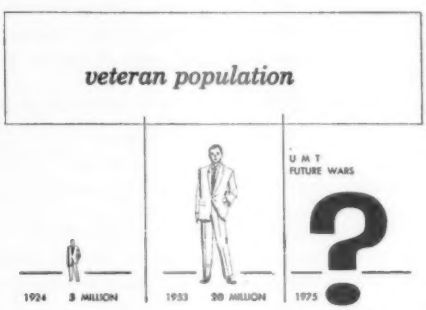
4. Within a few decades vitamins, sulpha drugs, the antibiotics and hormones have been added to the physicians' armamentarium against disease. American surgeons today are performing delicate, life-saving operations on the heart, lungs, brain, stomach, kidneys and other vital organs which just a few short years ago would have been impossiible. The past two years have brought heartening advances in the battle against infantile paralysis. News of successful trials of gamma globulin from human blood was followed with announcements indicating that the next two or three years may bring a vaccine effective against poliomyelitis.

5. For years we have advocated and strongly promoted the sale of voluntary health insurance as one of the aids to cushion the economic shock of illness. The growth of voluntary health insurance, which embraces benefits for hospital, surgical and medical expense, has been phe-

nomenal during the past few years. By January 1, 1953, nearly 92,000,000 Americans had some form of hospital expense benefit insurance. At that same time over 73,000,000 were protected by some form of insurance against the cost of surgical care and nearly 36,000,000 persons had coverage providing some medical expense benefits in addition to surgery. This amazing progress has been achieved without benefit of government subsidy.

In conclusion, Dr. Martin observed, "This nation's medical progress over the past half century has given the United States the world's highest standards of health and medical care and has made it the world center of medical education and research. That progress has been achieved under a voluntary system which emphasizes free enterprise, individual initiative and responsibility, and cooperative effort. It has been accomplished not by physicians alone but with the help and cooperation of allied professions, many branches of science, nurses, hospitals, business, industry, education and all segments of American society. Our most urgent effort should now be directed to the solution of the problem of the medically indigent and the chronically ill. We believe that this objective can be reached without major change in our existing mechanism."

In Viewing the VA Medical Program . . .



The U. S. veteran population now includes about 40% of all adult males. Under existing legislation, the federal government is obliged to provide "free" medical care for many of these veterans, if they request it. The medical profession questions the soundness of providing medical care at federal expense to veterans with non-service-connected disabilities. It is likely that by 1975 the U. S. will truly be a "nation of veterans." If the VA medical program continues to accept responsibility for the care of veterans with service-connected and non-service-connected disabilities alike it is difficult to see how a complete federal health program can be avoided.

For

antibacterial

therapy —

a more soluble, single sulfonamide with a wide antibacterial spectrum...especially soluble at pH of kidneys...hence minimizes need for alkalies...no record of renal blocking...GANTRISIN® 'ROCHE' (brand of sulfisoxazole).

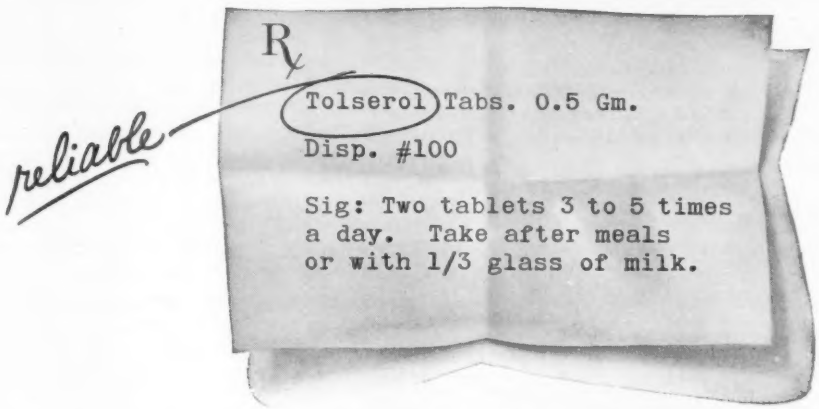
Levo-Dromoran

'Roche' —

"...A striking characteristic
is its ability to produce cheer-
fulness in pain-depressed patients
the morning after an evening dose..."
LEVO-DROMORAN® TARTRATE 'ROCHE' --
brand of levorphan tartrate.

Glazebrook, A. J., Brit. M. J.,
2:1328,(Dec. 20) 1952.

RAPID ABSORPTION—*MAXIMUM THERAPEUTIC EFFECT*



The clinical effectiveness of different brands of mephenesin tablets depends on their rate of absorption. A mephenesin tablet that disintegrates slowly is absorbed slowly. The resulting low blood levels may never produce a maximum therapeutic effect. Results with such a tablet are usually poor.

Tolserol Tablets are a result of extensive study and are formulated to disintegrate rapidly for fast absorption, thus maintaining optimum blood levels.

Tolserol

(*Squibb Mephenesin*)

Complete information on the use of Tolserol in muscle spasm of rheumatic disorders, in neurologic disorders and in acute alcoholism is available from the Professional Service Department, Squibb, 745 Fifth Avenue, New York 22, N. Y.

SQUIBB

LAUNCH GROUP PRACTICE STUDY

Interest in group practice has been on the upswing in the United States since World War II. However, since very little information is available on the subject, the A.M.A. has authorized a study of the entire question of group practice to be undertaken jointly by the Council on Medical Service and the American Association of Medical Clinics. The proposed field project, employing personal interviews rather than questionnaires, will seek to answer many of the questions concerning the organization and operation of group practice clinics which continually are directed to the A.M.A. Although no schedule has been set, it is hoped that the study will be completed by early fall.

Polio Vaccine Test Methods

Editor's Note: Although the nationwide polio vaccine tests scheduled to begin late this month will emphasize areas of heavy population and the test sites have not been announced, Rocky Mountain physicians should familiarize themselves with the plans to be followed, so they may better answer questions their patients will ask. If any Rocky Mountain communities are selected for some of the tests, such facts will be amply publicized at the time in the public press. In the meantime, the following information is offered by the National Foundation for Infantile Paralysis.

Two methods of conducting the nationwide polio vaccine tests this spring will be followed by the National Foundation of Infantile Paralysis, it was announced February 15 by Dr. Hart E. Van Riper, Medical Director.

Making public a letter from the National Foundation's Advisory Committee on Vaccination to the editor of the Journal of the American Medical Association, Dr. Van Riper stated that is some states half the school children in the first, second and third grades in selected counties will be given the trial vaccine and the other half will be given an ineffective substance. In other states children in the second grade only will receive the vaccine, with first and third grade pupils acting as statistical controls.

The combination of these two plans will assure a valid evaluation of the trial vaccine, he said. In case the amount of trial vaccine available is less than that originally contemplated, the committee recommended that by far the larger part of it be used in areas where the first plan can be properly administered.

The states in which the studies will be conducted are now being chosen, he added. Because of the necessity for additional facilities such as accessible virus research laboratories, only a few states will be selected to conduct the studies involving the giving of the vaccine to one-half the children in the first three grades.

The vaccine field trials are to begin in late March or early April.

The Advisory Committee on Vaccination consists of Dr. Thomas M. Rivers, Director, The

WHEN SYMPTOMS ARE DISTRESSING BUT DISGUISED . . .

"It is strange," Malleson says, "how little clinical recognition" has been given to the "negative behavior" or "endogenous misery" of the woman with endocrine imbalance. Largely accountable for this, of course, is the patient's own reluctance to discuss these symptoms with her physician until she actually suffers from some of the more obvious menopausal symptoms such as hot flushes. Even then she may become so accustomed to her change in feeling she can't remember what it's like to feel well.[1]

Changes in the mood pattern are just a few of the many distressing symptoms of declining ovarian function which are so often disguised because they do not always coincide with cessation of menstruation, and at times will occur long before, and even years after. Other good examples are insomnia, headache, easy fatigability, arthralgia — and understandably so, when one considers that the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism."[2]

"Premarin" is a preparation of choice for the replacement of body estrogen. "Premarin" presents a *complete* equine estrogen-complex and all the components of this complex are meticulously preserved in their natural form. This largely explains why "Premarin" not only produces prompt symptomatic relief but also imparts an important "plus" — the distinctive "*sense of well-being*" that patients find so highly gratifying. These benefits of "Premarin" have made it a natural estrogen widely prescribed by physicians . . . and often preferred by patients.

"PREMARIN."®

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

has no odor
. . . imparts no odor

Estrogenic Substances (water-soluble), also known as conjugated estrogens (equine), available in both tablet and liquid form

1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

NEW YORK, N. Y. Ayerst MONTREAL, CANADA

5409

Hospital of the Rockefeller Institute for Medical Research, New York City, who is Chairman; Dr. Thomas P. Murdock, Trustee, American Medical Association, Meriden, Conn.; Dr. David E. Price, Assistant Surgeon General, U. S. Public Health Service, Washington, D. C.; Dr. Joseph E. Smadel, Scientific Director, Department of Virus and Rickettsial Diseases, Army Medical Center, Washington, D. C.; Dr. Ernest L. Stebbins, Director, School of Hygiene and Public Health, Johns Hopkins University, Baltimore; Dr. Norman H. Topping, Vice President in Charge of Medical Affairs, University of Pennsylvania, Philadelphia; and Dr. Thomas B. Turner, Professor of Microbiology, School of Hygiene and Public Health, Johns Hopkins University, Baltimore.

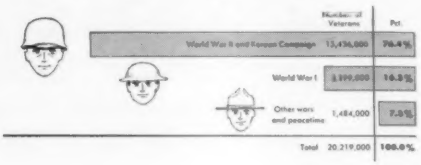
Detailed minimum standards for the preparation of the vaccine, approved by the Committee, have been sent to all State Health Officers. These standards incorporate "every reasonable safeguard possible," the committee declared.

"The data reviewed by the committee indicated that the three strains of virus are being produced in quantity;" the committee's letter stated, "that techniques are available for their inactivation, with rigid control for purity and safety; and that it is possible to conduct a controlled field study of its efficacy in the prevention of paralytic poliomyelitis.

In Viewing the VA Medical Program . . .

analysis of veteran population

PERIOD OF SERVICE



Taxpayers should note that as veterans grow older they require more frequent and increasingly longer periods of hospitalization. World War I patients are now hospitalized twice as long, on the average, as World War II patients with similar disabilities. World War II veterans, relatively young and comprising 76% of the total veteran population, present a costly long term responsibility to U. S. taxpayers. The medical profession recommends medical care through the VA for only those veterans with service-incurred disabilities and temporarily for those with tuberculosis or neuropsychiatric conditions of non-service-connected origin.

"Since safety is of the utmost concern, the committee has reviewed carefully a series of minimum standards prepared with the help of members of the committee and a number of consultants. The committee has recommended that these minimum standards be established for all material to be used in any field trial sponsored by the National Foundation. In the opinion of the committee, every reasonable safeguard possible has been incorporated in these standards, Since three separate laboratories will be carrying out the safety tests, chances of error will be remote indeed."

Dr. Thomas Francis, Jr., Chairman of the Department of Epidemiology in the University of Michigan School of Public Health, will direct an independent evaluation of the results of the trials.

New Mexico's Annual Meeting

The setting for the 72nd Annual Session of the New Mexico Medical Society will be at the end of the Old Santa Fe Trail in Santa Fe, May 13-15, 1954. It is fitting that a year of work and fellowship for the members of the New Mexico Medical Society should end in "The Different City."

The very sound of the name "Santa Fe" brings to mind "Fiesta"—gaiety, Indian markets, click of castanets, ripples of laughter—all in a happy, relaxed holiday mood.

Friends and neighbors will be present for this annual occasion of the New Mexico Medical Society. The weather will be ideal, between 40 and 60 degrees, and a few days of studying and relaxing will make your duties seem lighter upon your return home.

The Red Carpet will be rolled out for members of the State Society and guests on Wednesday, May 12. By 3:00 p.m., the La Fonda, headquarters for the convention, will be a bedlam of activity, with the exhibitors installing their exhibits and people checking into the hotel.

The Curry-Roosevelt County Medical Society, convention hosts, are arranging an outstanding convention which will not soon be forgotten. They have selected eight scientific speakers, with known abilities and knowledge, and include the following:

Charles L. Martin, M.D., Dallas, Radiology.

Harry Wilkins, M.D., Oklahoma City, Neurological Surgery.

Charles W. Mayo, M.D., Rochester, Surgery.

M. Edward Davis, M.D., Chicago, Obstetrics and Gynecology.

William Dameshek, M.D., Boston, Pathology.

W. A. Sodeman, M.D., Columbia, Mo., Internal Medicine.

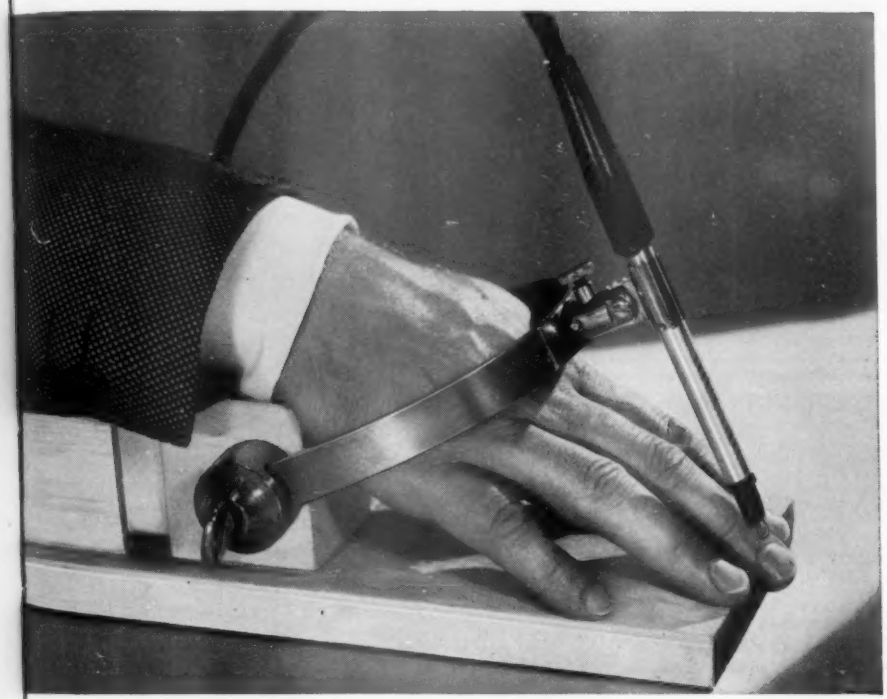
Gordon Meiklejohn, M.D., Denver, Internal Medicine.

Arild Hansen, M.D., Galveston, Pediatrics.

The business sessions of the Society promise to be lively and interesting, if the controversial subjects on the agenda are any indication. The Council will meet for dinner Wednesday evening, May 12, and the House of Delegates will convene at 8:30 a.m. Thursday. The second session of the House will meet Saturday at 12:30 p.m.

Included in the round of social functions will be a smoker for the men on May 13, at La Posada. On the smoker agenda is a surprise package, which you are sure to enjoy. The ladies will have dinner and entertainment at the La Fonda while their husbands are enjoying the smoker. The dinner-dance will be held May 14 in

Physiological test compares Kent's "Micronite" Filter with other cigarette filters



"KENT" AND "MICRONITE" ARE REGISTERED TRADEMARKS OF P. LORILLARD COMPANY

To compare the efficiency of various filters as they affect physiological responses in the cigarette smoker, drop in surface skin temperature at the last phalanx was measured.

Using well-established procedures, the subject smoked conventional filter cigarettes and the new KENT with the exclusive Micronite Filter.

For every other filter cigarette, the drop in temperature averaged over 6 degrees. For KENT's Micronite Filter, there was no appreciable drop.

These findings confirm the results of other scientific measurements that show these facts: 1) KENT's Micronite Filter takes out *far more* nicotine and tars than any other cigarette, *old or new*. 2) Ordinary cotton, cellulose or crepe paper filters remove a small but ineffective amount of nicotine and tars.

Thus KENT, with the first filter that really works, gives the one smoker out of every three who is susceptible to nicotine and tars the protection he needs . . . while offering the satisfaction he expects of fine tobacco.

For these reasons, smokers have made the new KENT the most popular new brand of cigarette to be introduced in the last 20 years.

If you have yet to try the new KENT with the exclusive Micronite Filter, may we suggest you do so soon?

the La Fonda. The Entertainment Committee has promised to employ a "big-name" band for the occasion.

We anticipate that Santa Fe will be bulging with doctors, come May 13-15, 1954, so you are advised to make your hotel reservations early. Send your reservations to: La Fonda, LaPosada, or Bishop's Lodge; or should you prefer to stay in one of Santa Fe's many nice motels, write the New Mexico Medical Society, 223-224 First National Bank, Albuquerque.

Obituary

CARL MULKY

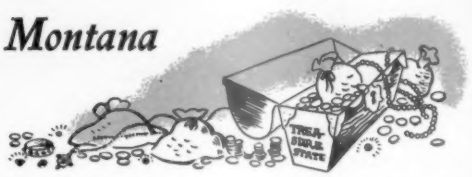
Dr. Carl Mulky of Albuquerque, a leader in the medical profession of New Mexico for more than a quarter century, died January 14, 1954, from a heart condition at the age of 77.

Dr. Mulky was a native of Knoxville, Iowa, and was graduated from the Chicago Homeopathic Medical College and also from Rush Medical college in 1901. He had practiced medicine in Albuquerque for thirty-three years, specializing in diseases of the chest. He was one of the founders of the New Mexico State Tuberculosis Sanatorium at Socorro, and was elected President of its medical staff just a week before his death.

He was also one of the founders of the Rocky Mountain Medical Conference and was a Past Chairman of the Conference. He likewise had been President of the New Mexico Medical Society, the Bernalillo County Medical Society, the New Mexico Trudeau Society, and the New Mexico Tuberculosis Association. Mrs. Mulky, who survives him, was the first President of the Woman's Auxiliary to the New Mexico Medical Society.

Dr. Mulky was a member of the Council of the New Mexico Medical Society at the time of his death, and had served in that position for many years. He was also a member of the American Medical Association, the American College of Physicians, and the American College of Chest Physicians.

Montana



Obituaries

J. H. HERRING

James Henry Herring, M.D., Lewiston, died January 4, 1954. He graduated from Trinity University in 1924 and received his M.D. degree from the University of Louisville School of Medicine in 1930. Doctor Herring had been engaged in the practice of ophthalmology, otology, laryngology and rhinology in Lewistown since 1939.

HERBERT HAYWARD

Herbert Hayward, M.D., of Hamilton, died January 4, 1954. Doctor Hayward received a B.S. degree in 1904 from Marquette College and an M.D.

degree from Milwaukee Medical College in 1908. He was a special consultant for the Rocky Mountain Laboratory for over twenty years and was chairman of the Montana Aeronautics Commission in 1947-48.

MEETING OF THE COUNCIL WYOMING STATE MEDICAL SOCIETY

Sunday, January 31, 1954

Gladstone Hotel, Casper

Councillors Present: Drs. Holtz, Chairman; Whedon, Phelps, Krueger, Beach, Jones, and Whalen.

Officers Present: Drs. Sampson, President; Sullivan, President-Elect; Tebbet, Secretary; and Mr. Abbey, Executive Secretary.

Guest Present: Dr. Anderson, President of Natrona County Medical Society.

The meeting was called to order by Chairman Holtz at 10:15 a.m.

1. The minutes of the Council meetings held June 11, 12 and 13, 1953, in Casper, were read and approved.

2. Discussion was held concerning mileage allowance for members of committee of Wyoming State Medical Society attending committee meetings. This matter will be referred to local County Societies and a request for discussion at the House of Delegates meeting in Sheridan in June. Dr. Sampson agreed that he would write to the local County Societies.

3. There was discussion held relative to the State of Wyoming's request for a charge of 50 cents per film for handling and postage for the x-rays which are sent to the T. B. Sanitarium at Basin. The following action was taken:

"It was moved, seconded, and passed that the Board of Councillors approved the request of the State of Wyoming that a fee of 50 cents be charged for postage and handling of x-rays read by Dr. Knable, Superintendent of the Tuberculosis Sanitarium at Basin, Wyoming, when the attending physician sends in the film and requests the reading."

4. Dr. Jones of Cody discussed the functions of the Committee on Professional Review. It was the consensus of the Council that Dr. Jones bring back to the Council, at a later date, recommendations as to the scope and jurisdiction of this committee after making a careful survey.

5. Some discussion was held concerning the work of the Medical Economic Committee in regard to a minimum fee schedule for the State Medical Society. There was no action taken on this point.

6. Discussion was held and a report given concerning the work done by the various County Medical Society Committees for the Blue Shield Preferred Program. It was also reported that a meeting would be held in Casper on February 7, 1954, and that the work of the committee was progressing very well.

7. Dr. Sampson reported on a meeting he had attended in Cheyenne with members of the State Department of Public Health, the Polio Foundation and the Executive Secretary. He elaborated on his letter recently sent out to all the members of the Wyoming State Medical Society.

8. Dr. Phelps reported on a letter that he had received from the Internal Revenue Department in regard to the Wyoming State Medical Society being exempt from paying income tax if the Medical Defense Fund were abolished. The following action was taken: Dr. Phelps was instructed to have a resolution ready for presentation to the House of Delegates at its next meeting in Sheridan in June, 1954.

9. Dr. Sampson read a letter from Dr. Lull of the American Medical Association concerning public health legislative matters and it was agreed that this should be referred to Dr. Ridgway, Chairman of the Public Health Liaison Committee.

10. The next item was discussion concerning the A.M.A. regional legislative meeting held in Denver, January 24, 1954. Dr. Sullivan reported for Dr. DeKay and Dr. Jones reported for Dr. Dominick. They outlined some of the discussion concerning legislative actions that would be coming up in the 83rd Congress that might affect the practice of medicine.

11. A discussion was held concerning editorial policies of the Rocky Mountain Medical Journal and also the possibility of a rate increase in subscriptions to this Journal. It was pointed out that the Journal has not had any rate increase since 1926. A meeting of the Editorial Board of the Rocky Mountain Medical Journal will be held in Denver during the Mid-Winter Clinic on February 17, 1954.

12. The Council called attention to the next Midwinter Clinics which will be held at the Shirley-Savoy Hotel in Denver February 16-19, 1954. All members of the Wyoming State Medical Society are urged to attend this meeting as it will be an exceptional meeting with outstanding speakers and fine exhibits.

13. Application for new membership in the

Thin, medium or thick, there is a thickness shim to give you a choice of 14 variations, from .008" to .034".

Graft Thickness *Accurately Controlled* with the REESE DERMATOME

The use of shims in industry has long been standard practice for the accurate control of thickness. This simple, fool-proof device applied to the REESE DERMATOME provides you with absolute accuracy of graft thickness control. Simply slide the shim of choice into the blade carrying yoke, followed by the cutting blade. Tighten blade clamp bar . . . that's all!

Another outstanding feature of the REESE DERMATOME is the Reese Dermatape technique, which so greatly simplifies the mechanics of skin graft transplanting. In brief, the Reese Dermatape technique . . .

1. Permits the cutting of multiple drums of skin without loss of operating time.
2. Facilitates handling of the graft after excision.
3. Simplifies transplanting graft to the lesion.
4. Eliminates suturing in many cases.
5. Assures a higher percentage of successful "take."
6. Conserves valuable operating time, and reduces hospitalization.

Mfg. by **BARD-PARKER COMPANY, INC.,** *Agent*

Send literature and price on the Reese Dermatome. RM-354

NAME.....

ADDRESS.....

CITY..... STATE.....

PHYSICIANS AND HOSPITAL SUPPLY CO., Inc.

1400 HARMON PLACE MINNEAPOLIS 3, MINNESOTA

Wyoming State Medical Society was approved for Frederick M. Young, M.D., of Kemmerer, Wyoming. Dr. Young graduated at the University of Pennsylvania in 1936. He was registered in Wyoming October 5, 1953, and is presently practicing in Kemmerer, Wyoming. This application was approved for membership by motion of Dr. Whedon and seconded by Dr. Phelps and unanimously passed.

14. Dr. Cedric Jones, Chairman of the American Medical Education Foundation for the State of Wyoming, reported on his trip to Chicago. Dr. Jones reported that the Wyoming physicians stand in a good position in per cent of contributions as compared to other states. Dr. Jones stated that Wyoming was in fourth or fifth place. The Council congratulated Dr. Jones on his fine work and recommended that all physicians in Wyoming be urged to give to this worthy cause. After luncheon, the meeting was adjourned at 1:30 p.m.

ANOTHER GOOD YEAR FOR BABIES

The Wyoming Department of Public Health has released its annual list of Wyoming physicians delivering 100 or more live babies in the preceding year. The figures are for the calendar year 1953, and the list includes twenty-three physicians.

Leading physicians in Wyoming for number of 1953 babies are:

1. Brugh, E. A., Fort Warren, 232.
2. Sullivan, B. J., Laramie, 230.
3. Kunckel, E. W., Casper, 212.
4. Young, C. M., Casper, 173.
5. Kattenhorn, L. D., Powell, 169.
6. Giovale, S. J., Cheyenne, 152.
7. Roberts, K. N., Casper, 151.
8. Engelman, A. A., Worland, 151.
9. Harrison, G. M., Rock Springs, 141.
10. Travis, Bane, Cheyenne, 140.
11. Treloar, O. L., Afton, 134.
12. Shwen, R. O., Cheyenne, 133.
13. Koford, G. W., Cheyenne, 132.
14. Hart, W., Casper, 120.
15. Smith, G. R., Fort Warren, 120.
16. Feigal, D. W., Fort Warren, 119.
17. Croft, T. B., Lovell, 111.
18. Schleyer, O., Cheyenne, 104.
19. Haigler, F. H., Casper, 104.
20. Kos, P. A., Rock Springs, 103.
21. Ashbaugh, R. D., Riverton, 102.
22. Waters, J. H., Evanston, 101.
23. Gitlitz, B., Thermopolis, 100.

PREFERRED BLUE SHIELD PLAN

Chairmen of the Blue Shield Committees for all the County Medical Societies in Wyoming met jointly in Casper on February 7 to discuss

the development of a new Preferred Blue Shield Plan for Wyoming. No final decisions were made, but it is anticipated that the fee schedules for services under such a plan will be set by the County Medical Societies by March 1, as a major step toward completion of a preferred plan. It was predicted that the income ceiling for service benefits will be fixed at approximately $4,500 per year for a family.

Colorado's Code Of Cooperation

In the fall of 1947, Dr. John S. Bouslog, then President of the Colorado State Medical Society, decided that something should be done to improve medical public relations, particularly with respect to newspapers and radio station news staffs. He recognized that there were areas of misunderstanding and lack of cooperation, but he felt that there were no problems which could not be solved by mutual understanding and frank discussion.

Accordingly, the State Medical Society was host at the first of a series of dinner discussions which resulted in formation of a committee to develop a Code of Cooperation between newspapers, radio stations, hospitals and the medical profession. The committee numbered about twenty-five persons with this representation:

Physician officers of the State Society and of the Denver Medical Society.

The President, Secretary and a member of the Board of the Colorado Hospital Association.

Managing Director of the Colorado Press Association.

Chief of the Time-Life Bureau.

News Editors of three Denver radio stations.

Editors and staff members of both Denver daily newspapers.

Representatives of executive staff, State Medical Society.

Director of the Rocky Mountain Radio Council.

The committee approached the problem with general agreement on these points:

1. Doctors and hospitals too often failed to cooperate with newsmen seeking prompt information on accidents, deaths and serious illnesses of

prominent people. Physicians also declined to be quoted on important medical and health developments when queried.

2. Some newspapers have been guilty of sloppy medical reporting and of sensationalism. This has tended to make the medical profession more reluctant to talk. (It was also recognized that some poor reporting was sometimes due to failure of physicians to tell the press the facts, thus making it necessary for them to do the best they could with what information they had.)

Several dinner meetings were held by the committee and paid for by the State Society. Committee members felt that mutual understanding and cooperation offered a solution to the problem. Doctors and hospital administrators learned something about news deadlines and about the speed with which newspapers and radio news staffs must operate. Newsmen were reminded that physicians, too, have their problems and their responsibilities to their patients.

Newsmen pointed out that there is great public interest in medical and health matters and that doctors should be quoted on legitimate stories in order to lend authenticity. They also suggested that physicians and hospitals could be more cooperative on accident and sickness cases. For example: one newsman said that if the mayor is hurt in an accident and taken to the hospital thirty minutes before a newspaper deadline, that paper would like to have the doctor advise (1) he's badly hurt or (2) his injuries appear to be minor or (3) he's dead. "We do not expect a case history," said the newsman. "But you surely do know whether the guy's O.K. or dead." It was also emphasized that medical reporting is greatly improved and that most newsmen can handle medical news properly and want to do so, and need only the confidence and cooperation of doctors and hospitals to do it.

A first Code draft resulted and mimeographed copies were sent to the presidents and secretaries of county medical societies for comment. Thus they were counted in on the important drafting of a Code. Quite frankly, a few doctors thought the Code would not work or was not necessary. Most of them, however, favored it.

After several dinner meetings the Code was finally approved by the committee. Everyone agreed that it probably wasn't perfect and that if it was to work, it would require plenty of cooperation and understanding. But it was hailed as a step forward and it has worked very well. During the dinners, newsmen and physicians and hospital administrators certainly got acquainted. They realized that the other fellow wasn't such a bad chap after all.

The night the final Code draft was approved witnessed an interesting development. Just before adjournment, the managing editor of one Denver daily announced that he felt the group was too important to dissolve, that it ought to meet six months later to compare notes on how the Code was working out. He invited the committee to be guests of his newspaper. The other managing editor present asked if his paper might not be a joint host at the affair. It was agreed and that dinner was held. At that time the Denver radio stations proposed to be hosts six months hence to keep the committee active.

The dinner with the radio stations as hosts was held June 16, 1949. The group talked shop and there were no major problems. At the conclusion

of the affair, the president of the Colorado Hospital Association announced that the association would be the next host.

The State Society was host for the 1951 dinner meeting and the Rocky Mountain News and the Denver Post were co-hosts at a dinner held January 10, 1952. The Denver area radio and TV stations were hosts February 4, 1953. The Colorado Hospital Association was host to the latest dinner, held February 25, 1954.

The committee dinners are always informal. There is no speaking program. Any physician or other member may bring up a problem, however, for discussion. There are never any serious ones because we handle them while they are still minor. It is mutually understood that cooperation is a two-way street. Doctors can't expect the press to handle their convention stories and other favorable publicity, and then fail to act when a request comes for help on a story involving, for example, a new drug.

The hospital association has encouraged its members to designate a spokesman for day and night to be available for calls from newsmen. The State Medical Society has encouraged each county society to designate a publicity chairman who shall handle contacts with press and radio. The State Society twice a year compiles a mimeographed list of State Officer, Executive Staff members and county society presidents, secretaries and publicity chairmen. This list goes to all editors, radio stations, telegraphic news service bureaus and other news points so that these sources know whom to call.

Further, the State Society authorizes its officers and committee chairmen and members and the officers and committee members of county societies to be quoted by press and radio on news developments. It is not unethical in this state for a physician-official to permit the use of his name in news stories in an official capacity.

The Code dinners, usually held in the spring, are separate and distinct from the annual press-radio dinner of the State Medical Society, held each November following the annual meeting in late September. The press-radio-TV dinner is primarily to introduce the new state officers to the press and radio. Attendance is about one hundred. The dinner is held in Denver and includes adequate representation of press and radio, although it is not possible to invite all the editors and radio men of the state to the affair. There is no formal speaking program at this dinner, either. It is largely a get-acquainted session.

The Code proper follows, and is reproduced in full:

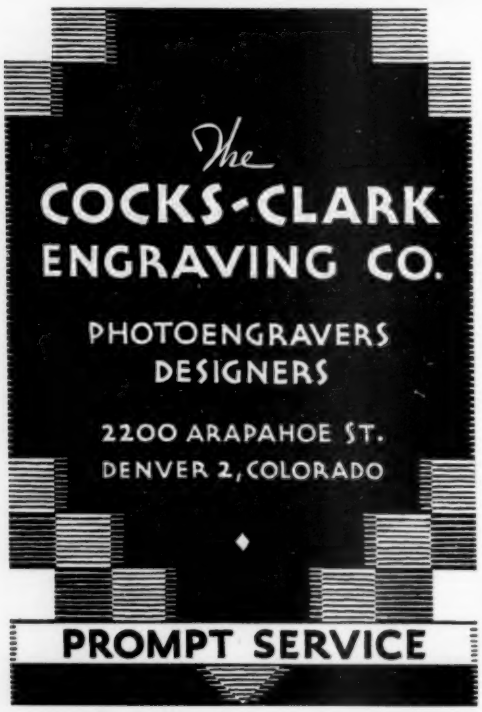
CODE OF COOPERATION

(As adopted April 16, 1948, by representatives of the press, radio, hospitals and medical profession of Colorado under the sponsorship of the Colorado State Medical Society and subsequently ratified by the constituted authority of that Society, the Colorado Hospital Association, the Colorado Press Association and the radio broadcasting industry of Colorado).

RESPONSIBILITIES OF THE COLORADO STATE MEDICAL SOCIETY

1. The executive offices of the Colorado State Medical Society shall be available at all times to representatives of the press and radio to obtain authentic information as promptly as possible on health and medical subjects. If the information desired is not immediately available, it shall be the duty of the executive offices either to obtain the information or to locate a competent authority from which the press and radio can obtain it directly.

2. Officers, committee chairmen or designated spokesmen of the Colorado State Medical Society may be quoted by name in matters of public interest for purposes of authenticating information given. A list of the current spokesmen of the



State Medical Society shall be supplied to the representatives of the press and radio and shall be kept up to date. This shall not be considered by their colleagues as a breach of the time-honored practice of physicians to avoid personal publicity since it is done in the best interests of the public and the profession.

3. County and regional medical societies in Colorado have been urged to adopt a similar policy in regard to their officers, committee chairmen and other designated spokesmen. It is recommended that county and regional medical societies prepare and keep up to date lists of current spokesmen comparable to those contemplated in paragraph two above, and supply them to their local press and radio representatives.

4. In matters of private practice, the wishes of the attending physician or surgeon shall be respected as to use of his name or direct quotation, but he shall give information to the press and radio where it does not jeopardize the doctor-patient relationship or violate the confidence, privacy or legal rights of the patient, as follows:

a. In cases of accident or other emergency: the nature of injuries when ascertained, the degree of seriousness, probable prognosis.

b. In cases of illness of a personality in whom the public has a rightful interest: the nature of the illness, its gravity and the current condition.

c. In cases of unusual injury, illness, or treatment the above information and any scientific information which will lead to a better public understanding of the progress of medical science. Any physician becoming aware of such a case is urged to notify the designated spokesman of his local medical society at once for immediate communication of appropriate information to the press and radio.

RESPONSIBILITIES OF HOSPITALS

1. Each hospital shall designate spokesmen who shall be competent, in the absence or non-availability of the attending physician, to give authentic information to the press and radio in emergency cases at any time of the day or night without the necessity of clearing with higher authority. These spokesmen shall be made known to the proper officials at all newspapers and radio stations in the community served by the hospital. Information shall be provided as rapidly as it can be obtained without interfering with the health of the patient. Nothing in this paragraph, however, contemplates the providing of any information which shall jeopardize the hospital-patient relationship, or which violates the confidence, privacy or legal rights of the patient.

2. In non-emergency cases, in the absence of

or on the authorization of the attending physician, hospitals shall provide information to the press and radio on the same basis as provided in Section 4 in the section on Colorado State Medical Society.

3. Where information is given on hospital procedure, equipment, facilities for treatment, or other features of hospital service, hospital authorities shall be careful to refrain from giving the impression that such facilities exist only in the hospital named unless that is the ascertained fact.

RESPONSIBILITIES OF PRESS AND RADIO

1. Representatives of the press and radio, recognizing that the first obligation of the physician and hospital is to safeguard the life and health of the patient, shall cooperate by refraining from any action or demands that might jeopardize the patient's life or health.

2. When a physician or hospital authority is quoted directly and by name, representatives of the press and radio shall make certain to the best of their ability that the quotation is accurate both in content and in context.

3. Representatives of the press and radio shall exercise editorial judgment to avoid publishing material designed solely to exploit the patient, doctor or the hospital.

4. On all matters of health or medical news, representatives of the press and radio shall make all reasonable effort to obtain authentic information from qualified sources indicated above before proceeding to publication or broadcast.

Supplement to the Code of Cooperation
December 1, 1952

TELEVISION

(Policies and responsibilities enumerated herein shall also apply to radio programming, being merely a reiteration of past procedure.)

Responsibilities of the Colorado State Medical Society

1. The Colorado State Medical Society has officially approved, through its Public Policy Committee, cooperation with TV on the same level and through the same means used so successfully with the radio industry. The Society proposes that the same cooperative, common-sense methods be followed and hereby declares its willingness to cooperate with TV through existing facilities of the Society.

2. The Executive Offices of the Society shall be available to TV personnel at all times for preliminary contact relative to TV programming. Where necessary the Executive Office shall guide the request to the proper medical society official or publicity chairman.

3. The State Society shall periodically remind its Publicity Committee, its Publicity Chairmen of component societies, and its entire membership of the obligation to cooperate with TV in the public interest, subject only to the policy limitations enumerated in this Code. Revised copies of the Code shall be distributed to managers, program directors and news editors of TV stations, and to publicity chairmen of county and district medical societies.

4. For purposes of clarity the State Society outlines the following general procedures, which have been followed in the past with radio:

1. A physician appearing on a program in a capacity other than as a representative of his profession, i.e., as county coroner, Rotary president, school board member, as a candidate for public office, etc., does not require any clearance for such appearance.

2. Officers, committee chairmen or designated spokesmen of the State Society or its components (see list of medical spokesmen) appearing on TV in connection wtih medical and health matters do not require clearance or approval. However, as a courtesy they should notify their county society publicity chairmen of the proposed appearance.

3. Speakers at the several medical meetings conducted annually by the State Society, may appear, if they desire, on TV programs arranged through the public relations department of the Society without the necessity of further clearance or approval. Likewise, in connection with any such meetings, local physicians whose presence is necessary to round out a panel or program, are considered to have approval for participation. Speakers at medical meetings not sponsored by the State Society, such as the American Academy of General Practice, the Rocky Mountain Radiological Society, the College of Chest Physicians, and others, are considered to have the same blanket clearance as mentioned above. Local physicians connected with such meetings also have the same privileges in conformity with the Code. However, the responsibility for arranging for participation of physicians involved in meetings not conducted by the Colorado State Medical Society shall rest with the sponsoring group and not with the State Society. Local physicians may clear such appearances through the Publicity Committee for their own protection if deemed desirable.

4. Requests for participation by one or more physicians in a program or programs projected by any of the various health statewide agencies, such as the Heart Association, Polio Foundation, Cancer Society, etc., and originating in Denver, shall have prior approval of the State's Society's Publicity Committee. Local chapters of such organizations presenting local programs shall obtain prior approval for physician participation from the Publicity Committee of the Denver Medical Society. Such programs originating outside of Denver should have approval of the local Publicity Chairman for M.D. participation.

5. As a general policy, the State Society will not approve participation of physicians in TV controversial political discussions or in debate on controversial issues (such as socialized medicine) unless specifically cleared.

6. Physicians who may be invited to discuss

matters which involve State Society policy shall first obtain clearance for said appearance and also for what they plan to say. Such occasions are comparatively rare, but would involve such policy and professional matters as state and national legislation, support of voluntary health insurance programs, nurses' education, use of new drugs, etc.

Responsibilities of Television

1. The television industry shall abide by the terms of the Code with respect to any and all sections which affect its operations.

2. It shall refrain from involving physicians in programs whose sponsors may be unacceptable to the medical profession, such as patent medicine advertisers.

3. It shall limit introductions of physicians to one essential identification, insofar as possible, such as "President of the Colorado State Medical Society" or "Chairman of the Committee on Rural Health" or "President of the Colorado Heart Association," and in such introductions shall avoid unnecessary "build-up" of the doctor or doctors involved.

From the evidence now available, there is no indication that shortly there may be a significantly decreased need for beds for tuberculosis patients.—Comm. on Therapy, Am. Rev. Tuberc., May, 1953.

Component Societies

EL PASO COUNTY

The El Paso County Medical Society is publicizing what it believes to be the first resolution adopted by a County Medical Society in support of the fluoridation of municipal drinking water. The resolution was presented by Dr. William C. Howell and was adopted by the Society on December 9, 1953, as follows:

"WHEREAS, There is substantial evidence that the water supply of Colorado Springs has contained a surplus amount (2.6 parts per million) of fluoride for a period of about seventy-five years;

BE IT RESOLVED, That, during the long practice of medicine in Colorado Springs, it is the considered opinion of the members of the El Paso County Medical Society that we have not experienced any clinical symptoms which can be attributed to the use of such water. It is known, however, that a condition known as "mottled enamel" can be produced by the use of water containing an excess of fluoride.

BE IT FURTHER RESOLVED, That this resolution be made a part of our permanent record and be put at the disposal of the dental profession.

GERALD H. SMITH,
Secretary.

NORTHEAST COLORADO

Drs. Morris H. Levine and Elston Huffman of Denver were guest speakers February 10 at the regular meeting of the Northeast Colorado Medical Society, held at the Sterling Country Club. The program was under the auspices of the Arthritis and Rheumatism Foundation, and was preceded by a dinner. The Society's next meeting is scheduled for March 17, also at the Country Club.

J. W. McDONALD, Secretary.

BOULDER COUNTY

"Newer Trends in Obstetrics" was the subject presented February 11 before the Boulder County Medical Society at its regular meeting, held at the Boulder Country Club. Dr. Arthur E. Klemme of Boulder was the essayist. Two new applications for membership were given their first reading at this meeting.

C. O. ROBERTS, Secretary.

Obituaries

FRANK N. COCHEMS

Dr. Frank Nicholas Cochems died December 31, 1953, at his Denver home, 491 Westwood Drive, after a short illness. He was born on June 24, 1868, in Sturgeon Bay, Wisconsin. After his graduation in 1891 from Northwestern Medical School in Chicago, he came to Salida, Colorado, where he practiced general surgery until he retired in 1940 and moved to Denver.

Dr. Cochems was a noted surgeon; he founded and owned the Red Cross Hospital in Salida. Many of his more delicate operations were performed at St. Joseph's Hospital in Denver.

He was an active member of the Colorado State Medical Society and the Denver Medical Society and was a former member of the Chaffee County Medical Society.

Dr. Cochems is survived by his wife, Jane Nugent Cochems.

CROZIER S. HART

Dr. Crozier S. Hart died at his home in Trinidad, Colorado, on January 6, 1954, following a heart attack. He was born in Huntington, Indiana, on May 24, 1894, and received his preliminary education in New Mexico. He received his A.B. in 1922 and his M.D. in 1925, both from the University of Kansas.

Dr. Hart served as company physician for a coal mining company at Dawson, New Mexico, for 20 years before moving to Trinidad in 1950, where he was director of the Las Animas County Public Health Department for the last three years. He was a veteran of World War I and an active member of the Colorado State and the Las Animas County Medical Societies.

Dr. Hart is survived by his widow and a sister.

HADDAN REAPPOINTED BY A.M.A.

Mr. Chester C. Haddan, Denver prosthetist, has been reappointed to the American Medical Association's Advisory Committee on Artificial Limbs. The appointment was announced by Dr. Frank H. Kruser, Chairman of the A.M.A. Council on Physical Medicine and Rehabilitation.

NEUROLOGY SEMINAR

An all-day seminar in Clinical Neurology will be held at the Boettcher School, Eighteenth and Downing Streets, Denver, on April 30, sponsored by the Rocky Mountain Pediatric Society. The guest speaker will be Dr. Douglas Buchanan. All physicians are invited to attend.

Medical School Notes

POSTGRADUATE OBSTETRICS AND GYNECOLOGY

A two-day postgraduate course in "Problems in Obstetrics and Gynecology for the General Practitioner" will be given at the University of Colorado School of Medicine on April 9 and 10, 1954. The guest lecturer will be Dr. John I. Brewer, Professor of Obstetrics and Gynecology, Northwestern University, who is one of the outstanding clinicians, writers and teachers in the field of gynecology.

The course is open to all physicians who are graduates of accredited medical schools. The registration fee is $5.00, payable at the time of registration, and is not refundable. The tuition fee is $20.00. All residents, interns and members of the faculty of the University of Colorado School of Medicine are cordially invited to attend the lectures without charge.

SUMMER POSTGRADUATE COURSE, COLORADO OPHTHALMOLOGICAL SOCIETY

The Postgraduate Course and Summer Convention of the Colorado Ophthalmological Society at the University of Colorado Medical Center in Denver, will be held July 26, 27, 28 and 29, 1954. The program will consist of lectures, seminars and demonstrations of interest to both the specialist and the practitioner caring for eye diseases.

Registration will be open to all members of the Society and qualified physicians on a limited membership basis.

POSTGRADUATE COURSE FOR PHYSICIANS AND HOSPITAL ADMINISTRATORS

A three-day postgraduate course in "Medical and Hospital Problems of Newborn and Premature Infants" will be given at the University of Colorado School of Medicine on March 24, 25 and 26, 1954. The afternoon session on Thursday, March 25, is co-sponsored by the Colorado Hospital Association.

The guest lecturers will be Ralph V. Platou, M.D., Professor, Department of Pediatrics, Tulane University Medical School, and Charles U. Letourneau, M.D., Secretary, Council on Professional Practice, American Hospital Association.

This course is open to all physicians, the registration fee is $5.00 and the tuition is $15.00. Interns and residents in hospitals affiliated with the University of Colorado School of Medicine are invited to attend without charge. There will be a regular meeting of the Rocky Mountain Pediatric Society during the period of this course. Physicians are invited to attend this official meeting. All hospital administrators are invited to the Thursday afternoon program. The registration fee for this part of the course is $5.00. There is no tuition. Each application must be accompanied by a $5.00 registration fee which is not refundable.

For applications and further inquiries about any of the above courses, write to the Director of Graduate and Postgraduate Medical Education, 4200 East Ninth Avenue, Denver 20, Colorado.

NON-FATTENING DIETETIC BEVERAGE

The White Rock Bottling Company now has available throughout the State of Colorado a line of non-fattening dietetic beverages marketed under the trade name of "Dietonic." These soft drinks are manufactured with Sucaryl Calcium (Cyclamate, Abbott) as their sweeting agent. There is neither sugar nor saccharine used.

These beverages afford an excellent way to add flavor and refreshment to your patients' low calorie, no sugar, salt-free diets, particularly for those whose craving for sweets adds to the difficulty of getting them to maintain their dietary menus. While these bottled drinks are as sweet and satisfying as the ordinary sugar-sweetened type, they contain less than nine calories per sixteen-ounce, no-deposit, no-return bottle. They are priced within the patient's budget, two big sixteen-ounce bottle retailing for 39 cents. They are available at drug stores, groceries, and other beverage dealers.

Produced to the rigid standard of quality and purity maintained by White Rock for over eighty years, Dietonic Carbonated Beverages are available in five flavors: Black Cherry, Lemon-Lime, Ginger Ale, Root Beer, and Cola; can be recommended with confidence to your patients and to your hospitals' dietitians.

Further information can be obtained in Denver from the White Rock Bottling Company, GRand 8164, or in Colorado Springs, MUlberry 5-5466.

WANTADS

FOR SALE: Like-new Jones metabolism machine, Cardiall electro cardiograph, Bausch and Lomb Microscope with stager darkfield condensor. Only used three months. V. E. Quitmeyer, M.D., Deer Lodge Clinic, Deer Lodge, Montana, Phone 258.

INHALATION MASK with gauges to connect with oxygen cylinder. New condition. Cheap. Dr. L. T. Moore, 1547 Arapahoe.

CAMERA CAUTERODYNE, practically new. $100. Excellent condition. Dr. G. H. Lee, 500 Williams, FR. 1264.

CAMERA HEARTOMETER. $150. Excellent condition. Dr. G. H. Lee, 500 Williams, FR. 1264.

FOR RENT — Physician's residential office. New building, air conditioned, ground floor, reception room, alcove, three examining rooms, laboratory, and private office. Hastings, Nebraska, is the medical center of Southwest Nebraska. Write Drs. Seberg and Seberg, 515 West 9th Street, Hastings, Nebraska.

OFFICE SPACE for rent. Denver, ideally situated out of down-town district. Adequate parking. Available immediately. For details telephone EAst 5202.

COMPLETING INTERNSHIP July 1st. Married, two children. Interested in general practice. Looking for permanent location in western Montana. For further information write Box 2, Rocky Mountain Medical Journal.

WANTED: Used x-ray and necessary related equipment, preferably 100 ma; used fcc approved diathermy. Contact E. J. Shidler, M.D., Brighton 770-W.

RELIABLE DRUGGISTS

PATRONIZE DENVER'S INDEPENDENT DRUGGISTS

Index to Advertisers

Confidence that grows with time

Only Dextri-Maltose enjoys a record of forty-three years of consistent and outstanding clinical success. No other carbohydrate for infant feeding has earned such worldwide acceptance and confidence in its constant dependability. Research continues to establish that whole milk and Dextri-Maltose formulas provide optimal nutrition for uncomplicated growth and development of infants.

Dextri-Maltose
does make a difference...

In bacteriologic safety
In convenience
In preventing "sweet tooth"
In true economy

DEXTRI-MALTOSE

THE CARBOHYDRATE OF CHOICE FOR INFANT FORMULAS

MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA, U.S.A.